Senate Select Committee on
MEDICAID REFORM

Lisa Carlton, Chair
Jeffrey H. "Jeff" Atwater, Vice Chair

Meeting Packet

Monday, December 5, 2005
9:00 a.m. – 12:00 noon
412 Knott Building

(Please bring this packet to the committee meeting. Duplicate materials will not be available.)

E X P A N D E D A G E N D A

SELECT COMMITTEE ON MEDICAID REFORM

Senator Carlton, CHAIR
Senator Atwater, VICE-CHAIR

DATE: Monday, December 5, 2005
TIME: 9:00 a.m. -- 12:00 noon
PLACE: The *Pat Thomas Committee Room,* 412 Knott Building

(**MEMBERS:** Senators Campbell, Clary, Dawson, Haridopolos, Miller, Peaden, Rich, Saunders and Villalobos)

TAB	BILL NO. AND INTRODUCER	BILL DESCRIPTION AND SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1		Presentation and review of the Agency for Health Care Administration's Medicaid reform implementation plan.	
2		Review and discuss Special Session bill relating to Medicaid.	
3		Development of recommendations relating to Special Session bill on Medicaid.	

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Florida
Medicaid Reform

Implementation Plan

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Executive Summary

The 2005 Florida Legislature created the Medicaid managed care pilot program in s. 409.91211, F.S. The law authorizes the Agency for Health Care Administration to seek a demonstration waiver, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program. The law requires the Agency to submit an implementation plan with budgetary projections of the effect of the pilot program on the total Medicaid Budget for the 2006-2007 through 2009-2010 state fiscal years as specified in s. 409.91211(6), F.S. This implementation plan was developed pursuant to s. 409.91211, F.S., and the Florida Medicaid Reform Waiver approved by the Centers for Medicare and Medicaid Services (CMS).

This document summarizes the implementation milestones and activities the Agency has undertaken and will complete to begin operation of the waiver on July 1, 2006, and, with legislative approval, expand statewide by 2011. In developing the implementation plan, the Agency has conducted outreach and education to obtain comments and share information through workshops with providers, advocacy groups, recipients, and all interested parties. Medicaid reform milestones include:

I. Pre-implementation:
   - Milestone 1: Comprehensive Outreach and Education Program
   - Milestone 2: Eligibility and Enrollment Process for Mandatory and Voluntary Populations
   - Milestone 3: Choice Counseling Program
   - Milestone 4: Managed Care Plan Contracting Process
   - Milestone 5: Payment Systems
   - Milestone 6: Medicaid Opt-Out Program
   - Milestone 7: Enhanced Benefit System
   - Milestone 8: Evaluation of Medicaid Reform
   - Milestone 9: Low Income Pool Pre-Implementation Milestones
   - Milestone 10: Budgetary Projections for Medicaid Reform – State Fiscal Years 2006-2007 through 2009-2010

II. Implementation:
   - Milestone 1: Implement Medicaid Reform in Broward and Duval Counties
   - Milestone 2: Implement Medicaid Reform in Baker, Clay and Nassau Counties
   - Milestone 3: Establish Specialty Plan Criteria and Contract in Broward and Duval Counties
   - Milestone 4: Complete Year 1 Milestones Established by CMS in Special Terms and Conditions

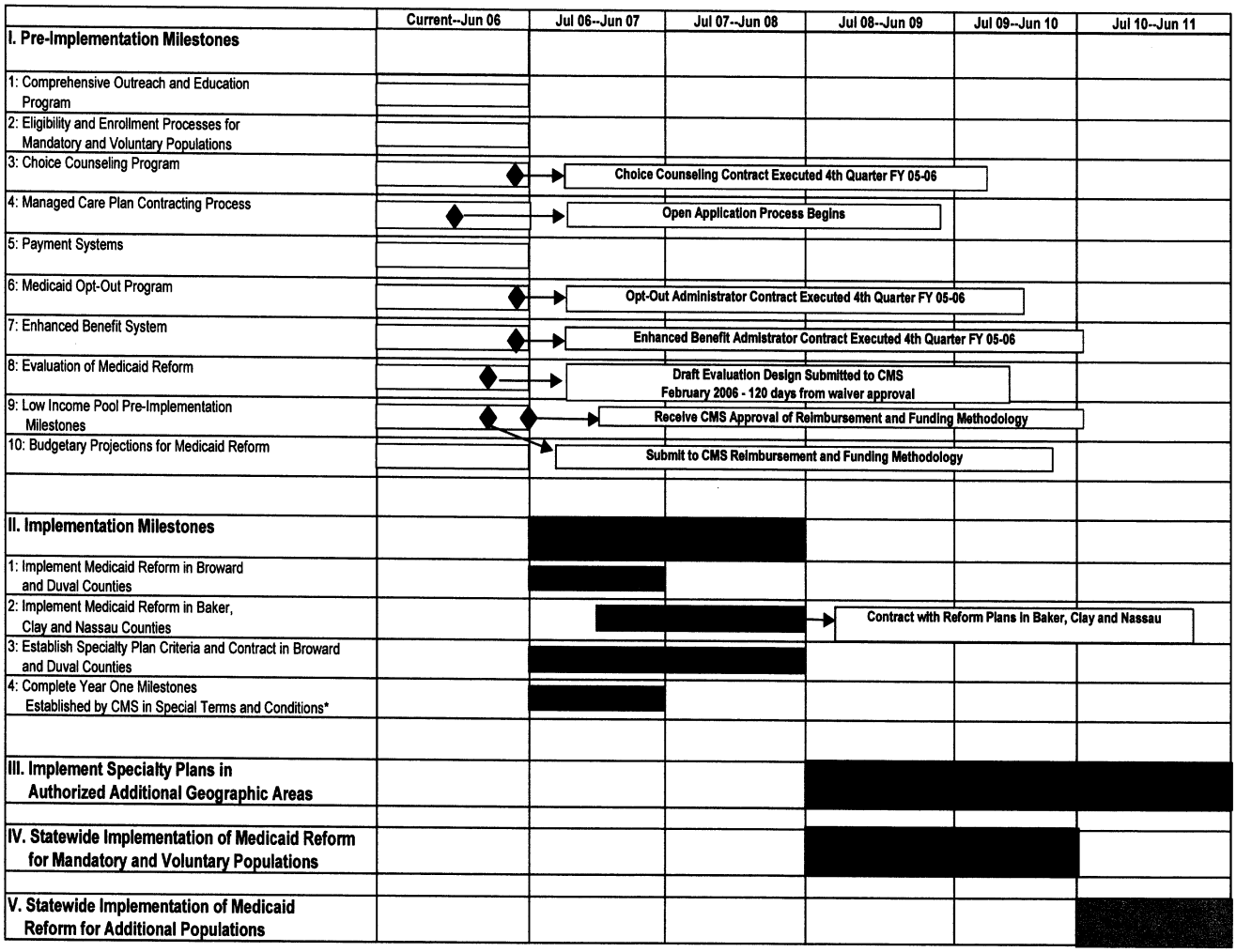
III. Implementation of specialty plans in authorized geographic areas

IV. Statewide implementation of Medicaid reform for mandatory and voluntary populations

V. Statewide implementation of Medicaid reform for additional populations

The next step is to seek legislative authority to implement the waiver in Broward and Duval Counties on July 1, 2006; and to expand the waiver to Baker, Clay and Nassau Counties within one year of becoming operational in Duval County.

Medicaid Reform Implementation Plan Schedule



* Specific Low Income Pool Milestones required throughout the term of the waiver

Medicaid Reform Implementation Plan

I. Pre-implementation Milestones and Activities for Medicaid Reform

Timeframe: Current through June 30, 2006

Upon passage in May 2005 of the legislation creating the Medicaid managed care pilot program, the Agency began to assess current programs and delivery systems, analyze operational functions, identify system gaps requiring new functions, and determine how to integrate them into the new Medicaid Reform service delivery system. This review resulted in the development of the milestones and activities contained in the implementation plan for Medicaid Reform.

The pre-implementation plan milestones include the restructuring and/or creation of the following systems, programs and processes:

Milestone 1: Comprehensive Outreach and Education Program

Milestone 2: Eligibility and Enrollment Processes for Mandatory and Voluntary Populations

Milestone 3: Choice Counseling Program

Milestone 4: Managed Care Plan Contracting Process

Milestone 5: Payment Systems

Milestone 6: Medicaid Opt-Out Program

Milestone 7: Enhanced Benefit System

Milestone 8: Evaluation of Medicaid Reform

Milestone 9: Low-Income Pool Pre-Implementation Milestones

Milestone 10: Budgetary Projections for Medicaid Reform – State Fiscal Years 2006-2007 through 2009-2010

Milestone 1: Comprehensive Outreach and Education Program

Description: The Agency has developed and continues to refine a comprehensive outreach and education program to facilitate a smooth transition to Medicaid reform by ensuring all affected individuals and parties are informed of changes and the potential impact. The Agency is partnering with community stakeholders, including local officials, small businesses, providers, and advocacy groups to increase awareness of Medicaid reform. The Agency is striving to ensure the workshops, public meetings, and written materials are effective in educating all interested parties about Medicaid reform.

The workshop topics include customized benefit packages, comprehensive and catastrophic financing components, actuarial equivalence and sufficiency tests, risk adjusted premiums, types of delivery systems, eligibility and enrollment, choice counseling, plan contracting process, plan readiness review, and plan standards and/or requirements (licensure, financial, credentialing, network capacity, cost sharing, marketing, grievance and appeals, encounter data, quality of care, quality improvement and assurance systems, program integrity, fraud and abuse).

Timeframes: Current through June 30, 2006

Activities:

1. Conduct meetings and workshops for providers.
2. Conduct meetings and workshops for recipients and advocacy groups.
3. Conduct focus groups with recipients.
4. Make information available on the Agency's web site, where official reform documents and updates are posted: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml
5. Publish notices to announce public meetings and workshops to provide updates and obtain public input on the implementation of Medicaid Reform.
6. Partner with community based organizations to identify and educate consumers.
7. Coordinate with other state agencies to participate in outreach and education.

Milestone 2: Eligibility and Enrollment Processes for Mandatory and Voluntary Populations

Description: The Agency evaluated the eligibility and enrollment processes for mandatory and voluntary populations in the demonstration area to ensure that clear, correct, and timely information is available. Since the actual eligibility criteria for Medicaid will remain unchanged, the focus will be on ensuring that the mandatory groups and those who volunteer to participate in reform are connected with a choice counselor as soon as possible.

Timeframe: Current through June 30, 2006

Activities:

1. Work with the Department of Children and Families (DCF) to ensure that necessary changes to the current eligibility process are in place.

2. Work with DCF to provide recipients timely access to choice counseling.

3. Incorporate written materials about choice counseling and reform in DCF's new-eligible notification mailings.

4. Work with DCF to ensure that recipients receive information about their choice of plans at eligibility re-determination.

5. Develop a process to provide choice counselors with eligibility redetermination data from DCF to initiate choice counseling. Such data will provide the choice counseling vendor the necessary information to contact recipients and provide them an opportunity to choose a reform plan or opt out to employer-sponsored insurance.

Milestone 3: Choice Counseling Program

Description: The Agency is developing a choice counseling program designed to ensure eligible recipients are fully informed of their choice of plans and will increase the number of voluntary selections.

Timeframe: Current through June 30, 2006

Activities:

1. Conduct research about choice counseling to analyze how other states have designed their choice counseling programs and to determine which programs have been most successful in increasing the number of voluntary plan selection.

2. Develop materials to assist recipients in making an informed choice of managed care plans.

3. Review the media options to determine the most effective methods to educate recipients about their plan choices (face-to-face, telephone, electronic, and web-based materials).

4. Conduct local public meetings to obtain input on the design of the choice counseling program.

5. Conduct focus groups with recipients to obtain input on the design of the choice counseling program.

6. Incorporate information gathered through research, public meetings, and focus groups into the design of the choice counseling competitive procurement document.

7. Contract with a Medicaid reform choice counseling vendor.

8. Contract with a qualified vendor for an independent evaluation of the choice counseling.

Milestone 4: Managed Care Plan Contracting Process

Description: The Agency is restructuring the contracting process for reform plans including capitated managed care plans and fee-for-service provider service networks to ensure the resulting contracts meet all applicable requirements of state and federal regulations. This process includes determining plan readiness and evaluation of plan benefit package.

Timeframe: Current through June 30, 2006

Activities:

1. Review and revise the current plan application for capitated plans to incorporate reform requirements and make them available to interested parties.

2. Review and revise the current plan application for fee-for-service provider service networks to incorporate reform requirements and make them available to interested parties.

3. Review and revise the current managed care plan readiness criteria to comport with reform and in compliance with all federal and state regulations. (See Attachment I, Managed Care Plan Readiness Process.)

4. Identify potential specialty plans for which plan applications will be considered (e.g. HIV/AIDS and children with chronic conditions).

5. Finalize and publish the reform plan data book to include fee-for-service claims experience and eligibility history for each designated target population in the demonstration area to assist plans in designing their benefit packages. (See Attachment II, Designing Benefit Plan for Medicaid Reform.)

6. Finalize the benefit plan evaluation prototype to ensure actuarial equivalency and sufficiency of benefits. (See Attachment III, Benefit Plan Evaluation Prototype.)

Milestone 5: Payment Systems

Description: The Agency is designing the reform payment systems to include comprehensive and catastrophic premiums. The Agency will contract with managed care plans including health maintenance organizations, exclusive provider organizations, licensed health insurers, specialty plans, and provider service networks.

Timeframe: Current through June 30, 2006

Activities:

1. Modify the current premium calculation system as necessary to pay participating capitated reform plans in compliance with federal and state regulations.

2. Design an interim risk adjustment payment system based on pharmacy encounter data.

3. Develop a standardized process to collect full encounter data from each reform plan.

4. Develop a standard, long-term risk adjustment payment which will be based on full encounter data.

5. Provide technical assistance to managed care plans related to submission of encounter data.

6. Establish methods/systems to collect and verify that the encounter data are complete and accurate.

7. Modify information systems as necessary to pay risk adjusted premiums to the reform plans.

Milestone 6: Medicaid Opt-Out Program

Description: The Agency will design the Medicaid opt-out program to ensure all recipients who have access to employer-sponsored insurance are provided an opportunity to opt out of Medicaid and select an employer-sponsored insurance plan. (See Attachment IV, Medicaid Opt-Out Program.)

Timeframe: Current through June 30, 2006

Activities:

1. Contract with a qualified vendor to operate the Medicaid opt-out program.
2. Develop the coordination process between the choice counselor, Medicaid recipient, the opt-out vendor and the Agency to ensure timely enrollment in the employer-sponsored insurance plan and timely and accurate payment by the Agency.
3. Develop the Medicaid opt out reporting system to comply with the federal special terms and conditions.
4. Develop a system to monitor the opt-out vendor's performance.

Milestone 7: Enhanced Benefit System

Description: The Agency will design the Enhanced Benefit System to provide incentives to Medicaid reform enrollees for healthy behaviors. (See Attachment V, Recommendations for Earning Enhanced Benefit Credits.)

Timeframe: Current through June 30, 2006

Activities:

1. Establish a seven-member Enhanced Benefits Panel to oversee policy development and guidelines for the program.
2. Issue a Request for Information (RFI) to obtain input on enhanced benefit systems.
3. Develop a competitive procurement document to select a qualified vendor to administer the Enhanced Benefit System.
4. Contract with a qualified vendor to administer the Enhanced Benefit System.

Milestone 8: Evaluation of Medicaid Reform

Description: The Agency will design and submit to CMS a draft evaluation design of Medicaid reform.

Timeframe: Current through February 19, 2006

Activities:

1. Contract for the evaluation with an independent entity.
2. Design the evaluation to incorporate criteria in the waiver and special terms and conditions.
3. Submit, as required by CMS, the draft evaluation design for approval within 120 days from waiver approval.

Milestone 9: Low Income Pool Pre-Implementation Milestones

Description: The Agency will comply with the required pre-implementation milestones established by CMS in the special terms and conditions of the waiver before the first payment from the low income pool.

Timeframe: Current through June 30, 2006

Activities:

1. Develop recommendations for the reimbursement and funding methodology document through the Disproportionate Share Hospital (DSH) Council.

2. Submit to CMS by March 1, 2006 and obtain CMS approval by June 30, 2006 of a reimbursement and funding methodology document for LIP expenditures, definition of expenditures eligible for federal match under the LIP and entities eligible to receive reimbursement.

3. Submit a State Plan amendment to terminate the current inpatient supplemental payment upper payment limit (UPL).

Milestone 10: Budgetary Projections for Medicaid Reform – State Fiscal Years 2006-2007 through 2009-2010

Description: Senate Bill 838 requires the Agency to evaluate the impact of Medicaid Reform on the total Medicaid budget for the 2006-2007 through 2009-2010 state fiscal years. (See Attachment VI, Budget Neutrality - Demonstration with Waiver and Attachment VII, Budget Neutrality - Demonstration Without Waiver.)

Timeframe: With submission of implementation plan.

II. Implementation Milestones and Activities for Medicaid Reform

Timeframe: July 1, 2006 through June 30, 2007

The Agency will establish the delivery system for Medicaid Reform in Broward and Duval Counties by July 1, 2006; and expand into Baker, Clay and Nassau Counties within one year of becoming operational in Duval County by July 1, 2007.

The implementation plan milestones include:

Milestone 1: Implement Medicaid Reform in Broward and Duval Counties.

Milestone 2: Implement Medicaid Reform in Baker, Clay and Nassau Counties.

Milestone 3: Establish Specialty Plan Criteria and Contract in Broward and Duval Counties.

Milestone 4: Complete Year 1 Milestones Established by CMS in the Special Terms and Conditions.

Milestone 1: Implement Medicaid Reform in Broward and Duval Counties

Timeframe: July 1, 2006 through June 30, 2007

Activities:

1. Continue the comprehensive outreach and education program initiated during pre-implementation period.

2. Implement all programs, systems, processes, and procedures established during the pre-implementation period.

3. Transition all interested current managed care providers to a reform plan in Broward and Duval Counties. (See Attachment VIII, Current Managed Care Programs in Broward and Duval Counties.)

4. Contract with new Agency-certified reform plans in Broward and Duval Counties.

5. Transition current Medicaid eligibles to a Medicaid reform plan. (See Attachment IX, Phase–In of Implementation.)

Milestone 2: Implement Medicaid Reform in Baker, Clay and Nassau Counties

Timeframe: July 1, 2006 through June 30, 2007

Activities:

1. Continue the comprehensive outreach and education program initiated during pre-implementation period. The Agency will refine the activities as needed to address the unique needs of these communities.

2. Open the plan contracting process to all interested applicants.

3. Implement all programs, systems, processes, and procedures established during the pre-implementation period.

4. Transition all interested current managed care providers to a reform plan in Baker, Clay and Nassau Counties.

5. Contract with new Agency-certified reform plans in Baker, Clay and Nassau Counties.

Milestone 3: Establish Specialty Plan Criteria and Contract in Broward and Duval Counties

Timeframe: July 1, 2006 through June 30, 2007

Activities:

1. Identify potential specialty plan populations based on eligibility or specified diagnosis.

2. Conduct education and outreach to specialty populations.

3. Develop managed care network and quality improvement standards to ensure the developmental, emotional, and medical needs of enrollees are met in Broward and Duval Counties.

4. Contract with specialty plans, if available, that meet the criteria established by the Agency in Broward and Duval Counties.

5. Monitor the specialty plans to ensure the financial reserves and the provider networks are sufficient to deliver accessible quality care to enrollees.

6. Contract with an independent entity to evaluate and determine the impact of specialty plans on hospitalizations, lengths of stay, emergency-room visits, costs, and access to care, including specialty care and patient and family satisfaction.

Milestone 4: Complete Year 1 Milestones Established by CMS in Special Terms and Conditions

Timeframe: July 1, 2006 through June 30, 2007

Activities:

1. Submit a final document to CMS that details the payment mechanism for expenditures made from the LIP to pay for medical expenditures for the uninsured and qualified aliens, including expenditures for 10 percent of the LIP used for other purposes as defined in the special terms and conditions within six months of implementation of reform in Broward and Duval Counties.

2. Comply with all the general reporting requirements as specified by CMS in special terms and conditions. (See Attachment X, Summary of CMS General Reporting Requirements.)

III. Implement Specialty Plans in Authorized Additional Geographic Areas

Timeframe: July 1, 2008 through June 30, 2010

Activities:

1. Open the plan contracting process for specialty plans in additional geographic areas to interested applicants.

2. Contract with Agency-certified specialty plans.

IV. Statewide Implementation of Medicaid Reform for Mandatory and Voluntary Populations

Timeframe: July 1, 2008 through June 30, 2010

Activities:

1. Continue enrollment of authorized mandatory and voluntary eligibility groups into Medicaid reform.

2. Conduct meeting and workshops, in areas where reform has not been implemented, to educate the public (providers, advocacy groups, recipients, and all interested parties), obtain input on Medicaid reform, and identify communities interested in transitioning to Medicaid reform.

3. Evaluate each county's readiness to transition to Medicaid reform by opening the Medicaid reform contract application process in a county or counties.

4. With Legislative consent expand Medicaid reform into additional counties outside the geographic areas initially authorized in s. 409.91211, F.S.

V. Statewide Implementation of Medicaid Reform for Additional Populations

Timeframe: July 1, 2010 through June 30, 2011

Activities:

1. Obtain approval from CMS to expand Medicaid reform to additional recipient populations.
2. Obtain Legislative approval to expand Medicaid reform to additional recipient populations by mandating enrollment of those Medicaid population groups previously enrolled voluntarily.
3. Enroll additional recipient populations.

Attachment I:
Managed Care Plan Readiness Process

Managed Care Plan Readiness Process

The Agency shall ensure that all reform plans demonstrate readiness by successfully completing the application process which, at a minimum, will include:

(1) **Organizational Review** – includes, but not limited to, a review of the applicant's business plan, background checks, licenses, Certificate of Authority and Health Care Provider Certificate if required, organizational structure, governing body policies and procedures, plan staffing, financial soundness, background and experience.

For provider service network applicants that are not required to obtain a Certificate of Authority or Health Care Provider Certificate, the organizational review also includes:

- Documentation of compliance with the definition of a provider service network as specified in s. 409.912(4)(d), F.S., as follows: "A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization."
- Documentation of applicant's prior authorization and claims management system including any required licensure standards as specified in Florida statutes. For example, applicants that delegate the administration and management of this process to a third party administrator (TPA), the applicant will be required to provide documentation that the TPA is licensed to do business as a TPA in the state of Florida as specified in s. 626.88, F.S.

(2) **Comprehensive Desk Review** – includes, but not limited to, a review of the applicant's provider network policies and procedures including credentialing and recredentialing procedures, availability/accessibility of services procedures, minimum provider network standards, specialty coverage procedures; model subcontracts; service authorization procedures including prior authorization procedures and time frame for decisions; out-of-plan use of emergency and non-emergency facilities; disease management procedures; staffing standards and procedures related to quality improvement/quality assurance, continuous quality improvement, independent peer review, quality indicators, utilization management; emergency care, case management and continuity of care, individuals with special health care needs, medical records, marketing,

enrollment and enrollment reporting procedures, enrollee information requirements; enrollment notices, new-enrollee materials, provider directory, handbooks, health risk assessment, disenrollment, grievances and appeals, fraud and abuse, Medicaid encounter data reporting, and systems to include running test reports with the Agency.

The comprehensive review also involves a fiscal analysis to determine plan solvency. Licensed entities must meet the licensing agency's solvency standards, and provider service networks must comply with the solvency standards specified in the Centers for Medicare and Medicaid-approved reform waiver.

(3) **Benefit Package Review** – includes a review of the applicant's proposed benefit package. The Agency will use an evaluation prototype to evaluate each benefit package using a two-pronged test: (a) actuarial equivalency and (b) sufficiency of benefits.

The Medicaid Reform flexible benefit designs will have to meet two distinct standards: actuarial equivalence to current Medicaid services and benefit sufficiency standards. Actuarial equivalence refers to the assurance that the proposed benefit plan offers as much total value as the current set of Medicaid benefits. Sufficiency tests check to see whether the proposed benefit plan offers enough of each of the services which the Agency has determined are most critical. Both of these tests are evaluated for the specific population targeted by the proposed benefit plan -- a benefit package that may be very appropriate for one population may be insufficient for another because of the populations' different medical needs, so it is important to take those diverse needs into account in the plan evaluation.

The Agency will use specially-designed plan evaluation software (the "Plan Evaluation Model") to test proposed plan designs for both actuarial equivalence and sufficiency of health care services. This model will include historical claims summaries for each target population for which health plans may design customized benefit packages. The model user will enter the proposed benefit specifications into the model's input screens, which will include information about amount, scope, and duration variation and copayment levels (if any). The model will then pull from its database the historical service utilization detail for the target population. Based on the target population's medical needs as illustrated in that claims history, the model will calculate the actuarial value of the proposed plan and compare it to the actuarial value of the standard package of Medicaid benefits. If the proposed benefit plan has at least as much value in aggregate, it meets the actuarial equivalence test.

Sufficiency tests are performed at the same time by the same tool, again using service-specific utilization detail for the specified target population. For instance, if the proposed plan places an annual dollar limit on a benefit such as pharmacy, the model will use the historical detail to determine the proportion of the target population that exceeds that benefit. If that proportion is higher than the pre-set standard for pharmacy, then the proposed plan would fail on the pharmacy sufficiency test. A similar test is performed for each of the services the state has

determined are critical enough to require sufficiency standards and testing. The Plan Evaluation Model will produce reports showing the proposed plan's performance on each of these tests. If the plan is determined actuarially equivalent and meets all sufficiency standards, it is approved as a Reform benefit plan for the specified population. (See Attachment II, Benefit Plan Evaluation Prototype.)

(4) On Site Review – includes an on-site visit by an Agency team and subsequent desk review of the findings. The Agency will be satisfied that network requirements are sufficient to serve enrollee needs.

Attachment II:
Designing Benefit Plans for Medicaid Reform

Designing Benefit Plans for Medicaid Reform

One of the key features of Florida's Medicaid Reform is the ability of health plans to vary the amount, scope and duration of current State Plan covered services to best meet the needs of the Medicaid recipients they enroll. This document will provide highlights of how health plans might design a benefit package to participate in Reform.

Plans should note that the state will make a standard risk-adjusted premium available to Medicaid Reform plans for the recipients they enroll. The state will provide base premium levels and a description of the methodology for risk adjustment development and application that plans can use to assess the expected financial results of the plan of benefits they develop. The state expects health plans to perform careful financial and actuarial modeling during the benefits design process, in order to assure the sufficiency of the level of services to be offered and the ongoing financial viability of the benefits they propose.

Generally, there are nine major steps that health plans will perform as part of the benefit package design process. Those steps are listed below, and then each is discussed in more detail. It is important to note that the same steps are followed, regardless of whether the health plan has elected to receive both the comprehensive and catastrophic premiums or has chosen to accept just the comprehensive premium.

Benefit Package Design Steps

1. Select the target population(s) to be served;
2. Assess the needs of the target population(s);
3. Consider any sufficiency standards and/or policy standards in effect for the population(s);
4. Determine which services will be covered under the Reform plan;
5. Develop cost estimates for services not covered under the current State Plan;
6. Develop cost sharing requirements for covered services;
7. Determine which, if any, services will vary in amount, scope, and duration versus current State Plan coverage;
8. Test resulting benefit packages for actuarial equivalence; and
9. Model expected plan revenue and costs to ensure ongoing financial viability.

Step 1: Select Target Population. Prior to designing the benefit package of a Reform plan, the health plan must identify the population(s) to be served by the plan. For each contract year, the state will designate "target populations" for which health plans can design plans. For the initial year of operation, the state expects to seek application for the following populations: TANF; SSI; TANF and SSI; Individuals diagnosed with HIV/AIDs and Children with Special Needs. A health plan can choose to develop benefit plans for any or all of the state-identified target populations. It is expected that

health plans will develop separate benefit packages for each target population to be served. However, a health plan could choose to develop one benefit package that would be available to all target populations.

Step 2: Assess the Population's Needs. Once the health plan has identified a target population, it should assess the target population's needs for medical care, including pharmaceuticals and behavioral health services. This assessment is essential in order for health plans to have the necessary information to design an effective plan of benefits. Assessments may include, but are not limited to: surveys of current enrollees, surveys of providers, review of claims history provided by the state, and reliance on other sources of knowledge about the Medicaid marketplace and the target population. Current Medicaid HMOs should have sufficient data on their enrollees to develop a benefit plan under reform. In addition, the state will provide all plans with a databook which will provide claims history of individuals enrolled in the fee-for-service program to ensure that the plan has the information needed to conduct an assessment.

Step 3: Consider Reform Standards. In order to be approved by the state, Reform benefit packages must meet prescribed standards. All plans will be required to provide all mandatory services and needed optional services for the target population. Certain services will have to meet "sufficiency standards" – these standards apply to key services, to ensure that the benefit package provides enough of those services to meet the needs of the members of the target population. For example, a sufficiency standard may be expressed as "pharmacy benefits must be sufficient to meet the needs of x% of the target population." In addition, for certain populations, the state will establish "policy standards" that all benefit packages must meet. Policy standards will apply to particular types of services and for select groups of individuals. For example, the state did not request a waiver for EPSDT therefore, plans must provide all medically necessary services for enrolled children. Sufficiency standards and policy standards may vary by target population and will be updated on an annual basis.

Each year the state will provide population-specific service utilization data for each type of benefit to which sufficiency standards apply. This data may be used by health plans to ensure their proposed benefit designs will meet sufficiency standards.

Step 4: Determine Covered Services. Based on the results of Steps 2 and 3, the health plan will decide what services will be covered in the benefit package. Plans must include all mandatory services, and optional services required to satisfy sufficiency standards. The needs assessment conducted by the plan may also identify other optional services or new services that should be included because they are important to the target population. As under the current system, the health plan may determine that for some types of services, it is appropriate to provide the services to children, but not to adults. An example of a service currently provided only to children is basic dental care.

Step 5: Determine Costs of New Services. As a result of the needs assessment, the health plan may determine that the target population would benefit from services not covered under the current State Plan. For each additional service proposed, the health

plan will be required to submit the estimated cost of providing the service to the target population, along with a supporting actuarial rationale. The rationale should include an estimate of the level of utilization expected, the average cost per service, and the resulting average per member per month (PMPM) value of the service.

Step 6: Develop Member Cost Sharing Requirements. Once covered services have been determined, the health plan should consider what cost-sharing, if any, should be applied to plan benefits. Any cost sharing imposed cannot exceed the currently approved nominal levels in the current State Plan. Certain individuals, such as children through age 18, pregnant women, and institutionalized individuals, are exempt by federal regulation from cost sharing. Federal regulations also prohibit the application of cost sharing to certain services, such as emergency services and family planning.

In making decisions about cost sharing levels, the health plan should consider how cost sharing can be used to encourage desirable behavior and not produce counter-productive results. For instance, if there is a copayment on physician office visits, but not on Emergency Room services, will patients choose to go to the ER when a physician visit would suffice?

Step 7: Determine variation in amount, scope and duration of covered services. In their assessment of the target population's needs, health plans may identify areas where varying the amount, scope, and duration of covered services may be appropriate. In some cases, services may need to be extended beyond what is currently allowed under the State Plan. For other types of services, the current State Plan may offer more services than are needed by the target population. In this step, the health plans will make these plan design decisions, subject to the assessment of the target population's needs in step 2 and the state standards as described in step 3.

Step 8: Test for Actuarial Equivalence. After proceeding through steps 1-7, health plans should have a draft benefit package constructed. At this point, the health plan should test to see whether the package is likely to meet the state's actuarial equivalence requirement. As has been discussed elsewhere, the state requires each benefit package to be actuarially equivalent in the aggregate to the current State Plan benefit package; this ensures that the overall level of services provided is appropriate for the premium received. The benefit package must be separately tested for actuarial equivalence to the State Plan package *for each target population* to which it will be offered.

The state's actuarial equivalence test will take into consideration all plan design elements discussed above. It will not consider variation in reimbursement levels between the health plan's benefit package and the State Plan, nor will it consider potential utilization increases or decreases due to increased utilization management or the behavioral impact of cost sharing.

Each year the state will provide utilization and cost data by type of service that health plans can use to evaluate actuarial equivalence for each potential target population.

Step 9: Model actual plan revenue and costs. Finally, the health plan should model the potential revenue and expenditures of the benefit package to ensure the offering fits within its business plan and will be financially viable.

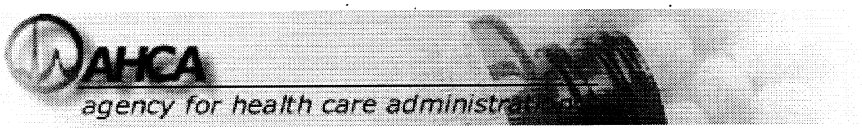
First, the health plan would model expected enrollment and project revenue associated with that enrollment, given the state's premium levels, risk adjustment methodology, and whether the health plan intends to accept the catastrophic premium and bear the associated risk. Premiums will be funded from the State's existing Medicaid budget; plans must ensure that both the medical and administrative expenses they incur on behalf of the target population can be funded at that premium level. Each year the state will provide base premium levels and risk adjustment information that can be used by plans in this revenue modeling.

Second, the plan would model expected medical and administrative costs associated with offering the benefit package to the individuals expected to enroll. In addition to the plan design characteristics outlined above, medical cost estimates would include the impact of utilization management on the number and mix of services used by the enrollees. These estimates would also reflect actual reimbursement arrangements the health plan has made or expects to make with providers. Administrative cost estimates will include the expected costs of administering the plan, including claims processing, enrollment processing, network management, overhead, and taxes.

Once the above steps are complete, the plan should have developed a customized benefit package that meets the state's requirement.

Attachment III:
Benefit Plan Evaluation Prototype

State of Florida Medicaid Reform Program - Plan Evaluation Model Prototype



Prototype Commentary: This User Input worksheet gathers information about the proposed plan: its targeted population, the geographic area in which it will be offered, and the benefit design.

A great deal of flexibility in benefit design will be accommodated in the final model, as shown in the benefit design input grid. The prototype provides examples of how annual benefit limits are evaluated for Total Inpatient Care, Total Prescription Drugs, and Outpatient Behavioral Health. It also provides examples of how co-pay differences can be evaluated, although the prototype does not value co-pays applied on a different basis than historical Medicaid (e.g., per day versus per admit). The prototype evaluates prescription drug limits on an annual basis against an unlimited benefit, whereas the current Florida Medicaid program has a monthly limit on brand name prescriptions.

Additional benefits (not historically covered by Medicaid) will be valued by the proposing entity and PMPM values input by AHCA into the model. The proposing entity will be required to submit supporting documentation to AHCA.

Step 1:

Enter Carrier Name	Florida Health Systems, Inc.
Enter Plan Name	Health Connections

Step 2:

Enter Contract Period

Contract Period	
Begin Date (MM/DD/YY)	07/01/05
End Date (MM/DD/YY)	06/30/06

Step 3:

Select Target Population(s)

Population Target	
Children and Families (Yes/No)	Yes
Aged and Disabled (Yes/No)	Yes

Step 4:

Select Target Region

Target Region	11
Pensacola Area	**1**
Tallahassee and Panama City Area	**2**
Gainesville and Ocala Area	**3**
Jacksonville and Daytona Beach Area	**4**
Clearwater/St. Petersburg Area	**5**
Tampa Area	**6**
Orlando Area	**7**
Ft. Myers Area	**8**
West Palm Beach Area	**9**
Ft. Lauderdale Area	**10**
Miami and Florida Keys	**11**

Step 5:

Enter Benefit Design Limits

PROTOTYPE IS RESTRICTED TO UNIT OR DOLLAR LIMITS (if both are input for same service dollar limit will be evaluated)
GRAY AREAS ARE NOT ENABLED IN PROTOTYPE

Benefit Design (Unit and Dollar Limits as Applied to Non-Pregnant Adults)

COVERED SERVICE CATEGORY	Covered for Adults	Covered for Children	Day/Visit Limit	Limit Period (Annual/Monthly)	Dollar Limit	Limit Period (Annual/Monthly)	Copay Amount	Copay Application
Inpatient Hospital	Y	Y	45	Annual		Annual		admit
Non-maternity Physical Health	Y	Y						
Maternity Care	Y	Y						
Behavioral Health	Y	Y						
Substance Abuse	Y	Y						
Skilled Nursing Facility	Y	Y						
Hospice	Y	Y						visit
Outpatient Hospital	Y	Y						visit
Physician Services	Y	Y						visit
Primary Care Physician	Y	Y						
Specialty Physician	Y	Y						
Physician Extender Services	Y	Y						visit
Pharmacy	Y	Y		Annual		Annual		script
Brand Pharmacy	Y	Y						
Generic Pharmacy	Y	Y						
Outpatient Therapy (PT/OT/ST)	Y	Y						visit
Outpatient Behavioral Health	Y	Y		Annual		Annual		visit
Outpatient Substance Abuse	Y	Y						visit
Home Health Services	Y	Y						visit
Lab Services	Y	Y						visit
Radiology	Y	Y						visit
Dental Services	Y	Y						visit
Vision Services	Y	Y						visit
Hearing Services	Y	Y						visit
Family Planning	Y	Y						
Durable Medical Equipment	Y	Y						
Transportation	Y	Y						trip

Prototype Commentary: This worksheet reports the results of the proposed plan evaluation for the Aged & Disabled Population. The report has 3 pages: Page 1 is the Summary, which shows the final decision, the actuarial equivalence percentage, and any sufficiency thresholds that were failed. Page 2 shows the sufficiency comparison detail, and Page 3 shows the actuarial equivalence comparison detail.

It is important to note that the sufficiency thresholds in this prototype are **examples**. Actual services to be evaluated are still subject to finalization, and appropriate thresholds will be developed as part of a detailed study of high cost claims and the catastrophic premium development.

The proposed plan is assumed to pass the actuarial equivalence test if it scores at least 100% of the actuarial value of the current State Plan benefits.

Proposed Plan Evaluation Report

Plan Name:	Florida Health Systems, Inc.: Health Connections
Target Region:	Area 11
Target Population:	Aged and Disabled
Effective Date	7/1/2005

AHCA Plan Approval Decision	**PASS**	
Actuarial Equivalence Results	**PASS**	101% of value of current State Plan benefits included in proposed plan
Benefit Sufficiency Results	**PASS**	All Sufficiency Thresholds Met

Prototype Commentary: This worksheet reports the results of the proposed plan evaluation for the Children and Families Population. The report has 3 pages: Page 1 is the Summary, which shows the final decision, the actuarial equivalence percentage, and any sufficiency thresholds that were failed. Page 2 shows the sufficiency comparison detail, and Page 3 shows the actuarial equivalence comparison detail.

It is important to note that the sufficiency thresholds in this prototype are **examples**. Actual services to be evaluated are still subject to finalization, and appropriate thresholds will be developed as part of a detailed study of high cost claims and the catastrophic premium development.

The proposed plan is assumed to pass the actuarial equivalence test if it scores at least 100% of the actuarial value of the current State Plan benefits.

Proposed Plan Evaluation Report

Plan Name:	Florida Health Systems, Inc.: Health Connections
Target Region:	Area 11
Target Population:	Children & Families
Effective Date	7/1/2005

AHCA Plan Approval Decision	***PASS***	
Actuarial Equivalence Results	***PASS***	***100% of value of historical Medicaid benefits***
Benefit Sufficiency Results	***PASS***	***All Sufficiency Thresholds Met***

Prototype Commentary: This worksheet reports the results of the proposed plan evaluation for the Children and Families Population. The report has 3 pages: Page 1 is the Summary, which shows the final decision, the actuarial equivalence percentage, and any sufficiency thresholds that were failed. Page 2 shows the sufficiency comparison detail, and Page 3 shows the actuarial equivalence comparison detail.

It is important to note that the sufficiency thresholds in this prototype are **examples**. Actual services to be evaluated are still subject to finalization, and appropriate thresholds will be developed as part of a detailed study of high cost claims and the catastrophic premium development.

In this prototype, the proposed plan is assumed to pass the actuarial equivalence test if it falls within 3 percent of the value of the historical Medicaid plan. The ultimate level of tolerance that will be used in plan evaluation is still not determined, but is expected to be small.

Proposed Plan Evaluation Report

Plan Name:	Florida Health Systems, Inc.: Health Connections
Target Region:	Area 11
Target Population:	Children & Families
Effective Date	7/1/2005

AHCA Plan Approval Decision	***PASS***	
Actuarial Equivalence Results	***PASS***	***100% of value of historical Medicaid benefits***
Benefit Sufficiency Results	***PASS***	***All Sufficiency Thresholds Met***

Attachment IV:
Medicaid Opt-Out Program

SUMMARY

Through comprehensive choice counseling, participants will be provided the opportunity to opt out of Medicaid into employer-sponsored plans. Consumers may use premiums to opt out of Medicaid to purchase insurance through the workplace. Consumers may also direct premiums into a private plan if the consumer is self-employed. The opt-out program will be a voluntary program.

A participant will be required to select a managed care plan or opt out within 30 days of eligibility. A participant who chooses to opt out and enroll in an Employer Sponsored Insurance (ESI) plan will be provided with a 90-day change period. The change period may be limited by the employer's open enrollment period. During this change period, the participant may opt back into Medicaid and select a managed care plan. After the change period, no further changes may be made until the consumer's open enrollment period, the next employer-sponsored open enrollment period, certain qualifying events or unless the enrollee no longer has access to ESI.

Individuals who choose to opt out will be eligible to receive care from an employer-sponsored insurer. Coverage will include individuals who have access to a qualified ESI health plan and COBRA coverage. A qualified ESI plan will include the following:

- Large employer groups – Health insurance coverage provided by Florida-licensed insurers to businesses with more than 50 employees.
- Small employer groups – Health insurance coverage provided by Florida-licensed insurers to businesses with one to 50 employees.
- Employee Retirement Income Security Act (ERISA) plans – Employers establish these plans to provide health insurance. The employer may contract with an insurance carrier to insure the plan or may opt for self-insurance. These plans are not regulated or licensed by the state.

If the ESI share or self-employed insurance premium is greater than the Medicaid premium, the consumer will be responsible to pay the additional amount.

PROCESS

- The choice counselor will provide information on either selecting a reform plan or opting out of Medicaid. They will provide information to individuals interested in opting out, explain the concept and reenrollment provisions and provide contact information regarding the state's contracted vendor. The choice counselor will also assist the individual in making an informed choice about opt out by highlighting information the individual will need to consider in order to make a fully informed choice.

- The choice counselor will collect information on whether the individual has access to health insurance.
- Individuals interested in opt out will be encouraged to contact their employer and the state's ESI contracted vendor for the opt out program for additional information.
- The choice counselor will notify the ESI contracted vendor of individuals who have access to insurance.
- The ESI contracted vendor will contact the individual's employer to verify the insurance available.
- The ESI contracted vendor will contact the individual and explain the insurance available through their employer and also advise of any costs the individual may have to accrue (e.g. if the ESI share or self-employed insurance premium is greater than the Medicaid premium, the individual will be responsible to pay the additional amount).
- If the enrollee chooses the opt out provision, the enrollee's information will be added to a database to be maintained by the ESI contracted vendor.
- The contracted vendor will follow-up with employers on a quarterly basis to verify continued employment.

EVALUATION

The following items will be evaluated in relation to the opt-out program.

1. Determine the basis of an individual's selection to opt out and whether the option provides greater value in obtaining coverage for which the individual would otherwise not be able to receive (e.g. family health coverage).

   During the enrollment process, the contracted vendor will enter in their database information as to what reason(s) the individual chose the opt out provision.

2. What is the participation in employer-sponsored insurance by Medicaid enrollees with access to ESI when compared to participation levels in similar Medicaid programs in other states?

   The contracted vendor will compare the enrollment in ESI plans in Florida with those in other states. The contracted vendor will submit questionnaires to other states in order to obtain this information.

3. What are the characteristics of individuals who choose to opt out?

   The contracted vendor will maintain demographic information on each individual enrolled in the opt-out program.

4. The number of enrollees under Medicaid Reform who are insured though private health coverage (ESI or other private coverage) in the year after losing Medicaid will increase as demonstrated by the difference in reenrollment in Medicaid.

The contracted vendor will maintain information in their database on the enrollment and disenrollment date from the opt-out program. The contracted vendor will also contact individuals on a regular basis to answer any questions regarding the -out program.

5. Evaluate the hypothesis that the rate of disenrollment for opt out during the 90-day disenrollment period for individuals who have opted-out will be less than the rate of disenrollment for Medicaid plans.

   The contracted vendor will maintain information in their database on the disenrollment date from the opt-out program. The contracted vendor will also contact individuals on a regular basis to answer any questions regarding the opt-out program.

6. Will the opt out option reduce Medicaid expenditures associated with the participating population?

   The contracted vendor will maintain data on the premium amount for each individual enrolled in the opt-out program.

7. Premiums paid on behalf of individuals who opt out will provide the state with per member per month savings when compared to the premium that would have otherwise been paid to a Medicaid reform plan.

   The contracted vendor will maintain data on the premium amount for each individual enrolled in the opt-out program.

REPORTS

The ESI contracted vendor will provide the following reports to the state.

1. The contracted vendor will provide to the state a quarterly report of enrollment data on ESI that documents the number of individuals selecting to opt out when ESI is available. The report shall include data that will identify enrollee characteristics as follows:

   a. Eligibility category
   b. Type of employer-sponsored insurance (e.g., small employer, large employer, ERISA)
   c. Type of coverage – single or family coverage

2. The contracted vendor will develop and maintain disenrollment reports specifying the reason for disenrolling in an ESI program.

3. The contracted vendor will track and report on those enrollees who elect the option to reenroll in the Medicaid Reform demonstration.

4. The contracted vendor will submit to the state the premium amounts that must be paid each month.

5. The contracted vendor will submit to the state a monthly invoice of all participants enrolled in the opt-out program. The contracted vendor will be paid a fee per individual enrolled in the program.

6. The contracted vendor must develop and maintain a database that contains at a minimum the following elements:

    - Enrollee Demographic Information
    - Employer Information
    - Reason(s) Enrollee Chose Opt Out Provision
    - Premium Amount
    - Premium Due Date
    - Employer Contact Dates
    - Enrollee Contact Dates
    - Disenrollment of Opt Out Provision Date
    - Reason(s) for Disenrollment

7. The contracted vendor will provide the state access to the database.

8. The contracted vendor will provide any additional reports as requested by the state.

MONITORING

The state will monitor the performance of the contracted vendor by conducting at a minimum the following activities:

1. Review of monthly invoice to determine all individuals included are enrolled in the opt-out program. This will include reviewing the database maintained by the contracted vendor; contacting a random sample of employers to verify the individual is still employed then contacting the insurance companies to verify the individual still has active coverage.

2. In addition to review of the invoice, the state will conduct the following monitoring activities on at least a quarterly basis:

    a. Contact a random sample of employers and insurance companies to verify the individual is employed and has active coverage.
    b. Submit questionnaires to a random sample of enrollees to provide their opinion on the service of the contracted vendor.

c. Submit questionnaires to a random sample of individuals who did not choose the opt out provision to determine their reason for not choosing this option as well as their opinion on the service of the contracted vendor.
d. Submit questionnaires to a random sample of individuals who have disenrolled from the opt-out program to determine their reason for disenrolling as their opinion on the service of the contracted vendor.

Attachment V:
Recommendations for Earning Enhanced Benefit Credits

Potential Healthy Behaviors / Practices

General Adult & Child	Participation (if eligible)	Additional Practices
Makes and keeps all primary care appointments	Disease management participation	Prescription drug regimen compliance
Adult age-sex appropriate preventive practices (mammograms, pap smears, colorectal screenings)	Alcohol and/or drug treatment program participation	Flu shot when recommended by physician
Childhood wellness visit	Smoking cessation program participation	Living will or advance directive completion
Childhood prevention care (age-appropriate screenings and immunizations)	Weight loss program	Age-appropriate documented exercise program
Childhood vision exam		
Childhood annual dental exam		

Attachment V.
Recommendations for Earnings Enhanced Benefit Credits

Sample List of Medical Service Covered by Enhanced Benefit Account

• Adult Routine Dental	• OTC or Brand-name Drugs
• Alcohol and Drug Treatments	• Stop-smoking Programs
• Bandages	• Telephone services for Hearing Impaired
• Contact Lenses	• Weight-loss Programs
• Dental Treatment	
• Eyeglasses	
• Hearing Aids	

Attachment VI:
Budget Neutrality – Demonstration with Waiver

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION								
AS SUBMITTED IN ORIGINAL WAIVER								
MANDATORY POPULATIONS								
ELIGIBILITY	DEMONSTRATION	MONTHS	DEMONSTRATION YEARS (DY)					TOTAL
GROUP	TREND RATE	OF AGING	DY 01 7/1/06-6/30/07	DY 02 7/1/07-6/30/08	DY 03 7/1/08-6/30/09	DY 04 7/1/09-6/30/10	DY 05 7/1/10-6/30/11	WW
MEG 1 - SSI RELATED								
Eligible Member Months	2.76%	33	3,150,897	3,237,968	3,327,845	3,420,646	3,516,494	
Total Cost Per Eligible	7.03%	26	$ 936	$ 1,002	$ 1,073	$ 1,150	$ 1,233	
Total Expenditure			$ 2,948,516,733	$ 3,242,956,545	$ 3,569,663,911	$ 3,932,622,123	$ 4,336,375,468	$ 18,030,134,780
MEG 2 - CHILD & FAM								
Eligible Member Months	9.67%	33	20,131,552	22,079,209	24,216,776	26,562,827	29,137,756	
Total Cost Per Eligible	6.23%	26	$ 192	$ 204	$ 217	$ 231	$ 246	
Total Expenditure			$ 3,866,100,441	$ 4,504,092,763	$ 5,253,744,917	$ 6,135,051,187	$ 7,171,616,475	$ 26,930,605,782

Attachment VI:
Budget Neutrality – Demonstration with Waiver

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION								
AS SUBMITTED IN ORIGINAL WAIVER								
LOW INCOME SUBSIDY POOL								
Eligible Member Months	0.00%		-	-	-	-	-	
Total Cost Per Eligible	0.00%		$ -	$ -	$ -	$ -	$ -	
Total Expenditure			$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 5,000,000,000
TOTAL EXPENDITURES WW D1-D5								
COMBINED ALL MEGS PLUS LOW INCOME								
SUBSIDY POOL			$ 7,814,617,174	$ 8,747,049,308	$ 9,823,408,828	$11,067,673,309	$ 12,507,991,943	$ 49,960,740,562
ELIGIBLE MEMBER MONTHS			23,282,449	25,317,177	27,544,621	29,983,473	32,654,250	
COST PER ELIGIBLE			$ 335.64	$ 345.50	$ 356.64	$ 369.13	$ 383.04	
TREND RATES								**5-YEAR**
					ANNUAL CHANGE			**AVERAGE**
TOTAL EXPENDITURE				11.93%	12.31%	12.67%	13.01%	12.48%
ELIGIBLE MEMBER MONTHS				8.74%	8.80%	8.85%	8.91%	8.82%
COST PER ELIGIBLE				2.94%	3.22%	3.50%	3.77%	3.36%

Attachment VII:
Budget Neutrality – Demonstration without Waiver

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION								
USING NEGOTIATED PMPM RATES PER FINAL SPECIAL TERMS AND CONDITIONS								
MANDATORY POPULATIONS								
ELIGIBILITY	TREND	MONTHS	DEMONSTRATION YEARS (DY)					TOTAL
GROUP	RATE	OF AGING	DY 01 7/1/06-6/30/07	DY 02 7/1/07-6/30/08	DY 03 7/1/08-6/30/09	DY 04 7/1/09-6/30/10	DY 05 7/1/10-6/30/11	WOW
MEG 1 - SSI RELATED								
Eligible Member Months	2.76%	33	3,150,897	3,237,968	3,327,845	3,420,646	3,516,494	
Total Cost Per Eligible	8.00%	33	948.79	1,024.69	1,106.67	1,195.20	1,290.82	
Total Expenditure			$ 2,989,539,607	$ 3,317,923,683	$ 3,682,822,048	$ 4,088,363,572	$ 4,539,154,597	$ 18,617,803,507
MEG 2 - CHILD & FAM								
Eligible Member Months	9.80%	33	20,131,552	22,079,209	24,216,776	26,562,827	29,137,756	
Total Cost Per Eligible	8.00%	33	199.48	215.44	232.67	251.29	271.39	
Total Expenditure			$ 4,015,842,012	$ 4,756,709,480	$ 5,634,601,332	$ 6,674,902,406	$ 7,907,705,387	$ 28,989,760,616

Attachment VII:
Budget Neutrality – Demonstration without Waiver

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION								
USING NEGOTIATED PMPM RATES PER FINAL SPECIAL TERMS AND CONDITIONS								
HOSPITAL INPATIENT SUPPLEMENTAL PAYMENTS								
Eligible Member Months	0.00%	33	-	-	-	-	-	
Total Cost Per Eligible	20.33%	33	$ -	$ -	$ -	$ -	$ -	
Total Expenditure			$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 5,000,000,000
TOTAL EXPENDITURES WOW D1-D5								
COMBINED ALL MEGS WHICH								
INCLUDE TOTAL HOSPITAL UPL			$ 8,005,381,618	$ 9,074,633,163	$ 10,317,423,381	$11,763,265,977	$ 13,446,859,984	$ 52,607,564,123
ELIGIBLE MEMBER MONTHS			23,282,449	25,317,177	27,544,621	29,983,473	32,654,250	
COST PER ELIGIBLE			343.84	358.44	374.57	392.32	411.80	
TREND RATES								**5-YEAR**
					ANNUAL CHANGE			**AVERAGE**
TOTAL EXPENDITURE				13.36%	13.70%	14.01%	14.31%	13.84%
ELIGIBLE MEMBER MONTHS				8.74%	8.80%	8.85%	8.91%	8.82%
COST PER ELIGIBLE				4.25%	4.50%	4.74%	4.96%	4.61%

Attachment VIII:
Current Managed Care Programs in Broward and Duval Counties

Current Delivery Systems	Broward	Duval
Health Maintenance Organization – HMO	7	1
Provider Service Network – PSN	1	-
Minority Physician Network – MPN	2	1
Emergency Room Diversion Program	1	-
Total	***11***	***2***

As of November 2005, there were 11 managed care entities in Broward County and 2 managed care entities in Duval. The state anticipates that all HMOs and PSNs that currently contract will continue to provide services under reform. The Minority Physician Networks and ER Diversion Program are expected to create a PSN to provide services under reform.

In addition to the current contractors, the state has received several inquiries from new plans that have expressed an interest in participating in reform. With the entry of new managed care plans, individual choice will be increased in the reform sites, when compared to the period prior to implementation.

Attachment IX:
Phase-In of Implementation

Roll Out Reform Plan in Duval and Broward Counties

The tables below indicate Reform will start in Broward and Duval Counties and provide an overview of the transition. The model assumes that during the transition period, there will be 134,065 individuals in Broward County and 78,124 in Duval County enrolled in a managed care plan under Reform. Both models exclude children enrolled in Children's Medical Services in the initial roll-out. These figures are the current managed care enrollment levels as of June 2005 and do not include unassigned individuals. No increase in new eligibles or total enrollment is assumed. Below is a summary of the transition in the first year.

Broward County

As of June 2005, the state contracts with one PSN, two MPNs and one ER diversion program with a total enrollment of 34,881. The state also contracts with seven HMOs with a total enrollment of 74,121. The current managed care plans will have to apply as a reform plan to participate. The Agency assumes that there will be at least two managed care reform plans. If all plans continue as reform plans, there will be at least 11 managed care choices. Individuals in MediPass will be required to select a reform plan at the time of eligibility redetermination. The model assumes that one-twelfth of the current managed care enrollees will transfer to a managed care plan under Reform every month. These enrollees are assumed to choose or be assigned to an HMO or PSN equally. Enrollees in a PSN, MPN, or ER diversion program will also be given the opportunity to change plans at the time of redetermination. However, should the plan participate under Reform, it is assumed that the individual will elect to remain enrolled in the same plan. At the end of the transition period, enrollment in PSN reform plans and managed care reform plans is estimated to increase by 12,531, which represents half of the total MediPass enrollment at implementation.

Broward County	**4/1/2006-6/30/2007**	
	Start	**End**
PSN-MPN-ER Diversion (4)	34,881	-
HMO (7)	74,121	-
MediPass	25,063	-
PSNs Reform	-	47,413
HMOs Reform	-	86,653
Total Enrollment in Reform		**134,065**

Duval County

As of June 2005, the state contracted with one MPN with a total enrollment of 3,826 and one HMO with a total enrollment of 41,418. The Agency assumes that if both plans continue as reform plans, there will be at least two managed care choices. Therefore, individuals in MediPass will be required to select a reform plan at the time of eligibility redetermination. It is assumed that one-twelfth of the current managed care enrollees will transfer to a managed care plan under Reform every month. These enrollees are assumed to choose or be assigned to an HMO or PSN equally. Enrollees in the MPN or HMO will also be given the opportunity to change plans at the time of redetermination. Should a plan participate under Reform, it is assumed that the individual will elect to remain enrolled in the same plan. At the end of the transition period, enrollment in PSN reform plans and managed care reform plans is assumed to increase by 16,440, which represents half of the total MediPass enrollment at implementation.

Duval County	**4/1/2006-6/30/2007**	
	Start	**End**
PSN-MPN	3,826	-
HMO	41,418	-
MediPass	32,880	-
PSN Reform	-	20,266
HMO Reform	-	57,858
Total Enrollment in Reform		**78,124**

Assumptions:

- Enrollment levels as of June 2005 are assumed to remain the same at the time of implementation
- Enrollment choice will be made at redetermination of Medicaid eligibility.
- The total managed care eligible population will go through redetermination within 12 months
- Enrollment choices are estimated to be made by 1/12 of the total population each month in each county
- In Broward County there will be 2,088 choosers from MediPass each month, 6,177 choosers from the HMO each month, and 2,656 choosers from the PSN-MSN each month.
- In Duval county there will be 2,740 choosers from MediPass each month, 3,451 choosers from the HMO each month, 319 choosers from the MPN
- The split between the new reform plans will be 50%-50% for MediPass enrollees
- People currently enrolled in a PSN, MPN or HMO are assigned to the reform choice of the current choice (100% of PSN goes to PSN reform, 100% of HMO goes to HMO reform)

Actual experience may deviate from the estimates.

Attachment X:
Summary of CMS General Reporting Requirements

Summary of CMS General Reporting Requirements

1. General financial reporting requirements include submission of quarterly expenditure reports on total expenditures for services provided as specified in Section XVIII of the Special Terms and Conditions.

2. Budget neutrality reporting requirements for monitoring budget neutrality as specified in the waiver.

3. Managed care data requirements include requiring by contract that all managed care organizations maintain an information system that collects, analyzes, integrates and reports data pursuant to 42 CFR 438.

4. Monthly calls to discuss any significant developments affecting the Medicaid Reform waiver including, but not limited to, managed care organization operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, the benefit package, enhanced benefit accounts program, choice counseling activities, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or State Plan amendments the state is considering submitting.

5. Quarterly reports will be submitted to the Centers for Medicare and Medicaid Services no later than 60 days following the end of each quarter to present the Agency's analysis and the status of various operational areas. The reports will include, but shall not be limited to:

    a. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues.

    b. Action plans for addressing any policy and administrative issues.

    c. State efforts related to the collection and verification of encounter data, and utilization data.

    d. Enrollment data disaggregated by plan and by the following specifications: eligibility category, TANF or SSI, total number of enrollees; market share; and percentage change in enrollment by plan. In addition, the Agency will provide a summary of voluntary and mandatory selection rates and disenrollment data.

e. For purposes of monitoring budget neutrality the quarterly reports shall include enrollment data, member month data, and expenditures in the budget neutrality-monitoring format provided by CMS.

f. Low Income Pool activities and associated expenditures.

g. Activities related to the implementation of choice counseling including efforts to improve health literacy and the methods used to obtain public input including recipient focus groups.

h. Participation rates in the Enhanced Benefit Accounts Program. This shall include: participation levels; summary of activities and the associated expenditures; number of accounts established including active participants and individuals who continue to retain access to funds in an account but no longer actively participate; estimated quarterly deposits in accounts, and expenditures from the account.

i. Enrollment data on employer-sponsored insurance (ESI) that documents the number of individuals selecting to opt out when ESI is available. The Agency will include data that will identify enrollee characteristics as specified.

j. Progress toward the demonstration goals.

k. Evaluation activities.

6. The annual report includes the submission of a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the reform waiver no later than 120 days after the end of each operational year. The final report shall be submitted within 30 days of the draft annual report. The Agency will include, beginning with the second annual report, a section on the administration of Enhanced Benefit Accounts, participation rates, an assessment of expenditures, and potential cost savings. The Agency will include, beginning with the fourth annual report, a section that provides qualitative and quantitative data that describes the impact the Low Income Pool had on the rate of uninsurance in Florida starting with the implementation of the waiver.

SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Health Care Committee

BILL: SB 0002B

INTRODUCER: Senators Peaden, Carlton, and Atwater

SUBJECT: Medicaid Reform Implementation

DATE: December 3, 2005 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HE	**Pre-meeting**
2.				
3.				
4.				
5.				
6.				

I. Summary:

This bill provides the Agency for Health Care Administration (AHCA) the authority to implement the Medicaid managed care pilot program as specified in CS/CS/SB 838 (ch. 2005-133, L.O.F.) and in accordance with the federally-approved Medicaid waiver application and special terms and conditions received in October 2005. Specifically, the bill:

- Authorizes AHCA to begin implementing the Medicaid capitated managed care pilot program in two demonstration sites (Broward and Duval Counties per CS/CS/SB 838).
- Provides for statewide expansion of the program in accordance with the process in the federally-approved special terms and conditions, which requires legislative approval of expansion into additional sites, with the goal of full statewide implementation by June 30, 2011.
- Abolishes the Medicaid Disproportionate Share Council and replaces it with the Medicaid Low-Income Pool Council. The Council will make recommendations to the Legislature regarding the Low Income Pool which replaces the UPL funding program for safety-net hospitals. The bill establishes objectives to guide the distribution of funds from the low-income pool.
- Excludes managed care pilot program counties from the current requirement for AHCA to provide comprehensive behavioral health care services to Medicaid recipients on a capitated, prepaid basis.
- Requires Medicaid provider service networks to comply with certain federal solvency requirements, rather than the state solvency requirements for HMOs. Eliminates the requirement that AHCA competitively bid contracts with provider service networks. Requires provider service networks established in a managed care pilot area that are

reimbursed on a fee-for-service basis to include a savings-settlement mechanism to share savings with the state.

- Authorizes AHCA to seek options for making direct payments to hospitals and physicians employed by or under contract with the state's medical schools for the costs associated with graduate medical education under Medicaid reform.
- Requires managed care networks in the demonstration sites to include in their networks the Department of Health's Children's Medical Service Network, to the extent possible.
- Establishes detailed standards for managed care plan compliance, including quality assurance and outcome measures and a patient-encounter reporting requirement.
- Establishes detailed requirements to minimize the risk of Medicaid fraud and abuse in all plans operating in the Medicaid managed care pilot program.
- Requires AHCA to assign Medicaid recipients who are currently in a Medicaid managed care plan and who do not make a choice of plans during the reform enrollment process, or at the point of eligibility redetermination, into the most appropriate reform plan operated by the recipient's current managed care plan.
- Requires AHCA to submit proposed changes to the approved special terms and conditions to the Legislature before submitting them to the federal government and requires AHCA to report to the Legislature any changes that are approved by the federal government.
- Specifies Legislative intent that, if any conflict exists between the statutory provisions relating to reform and other Medicaid statutes, the reform requirements prevail. AHCA must report to the Legislature any conflicts they identify during implementation.
- Requires AHCA to report to the Legislature by April 1, 2006, regarding negotiations with the federal government over the Low Income Pool and to submit to the Legislature quarterly and annual reports regarding implementation of the pilot projects.

The bill is effective upon becoming law.

This bill amends ss. 409.911, 409.912, 409.91211, and 641.2261, Florida Statutes. The bill also creates s. 409.91213, Florida Statutes, and an undesignated section of law.

II. Present Situation:

The Governor's Medicaid Reform Proposal

On January 11, 2005, Governor Bush released a Medicaid reform proposal (originally called Empowered Care) for consideration by the Legislature. The proposal is based on data demonstrating that the current Medicaid budget is growing at an unsustainable rate and that a comprehensive overhaul of the system is necessary to improve care and provide predictability in the state Medicaid budget.

The Governor's proposal centers on the concept of moving Medicaid recipients out of the current fee-for-service system into a mostly managed care environment. In this new system, managed care plans (including traditional Medicaid HMOs and new provider service networks) will receive actuarially-sound, risk-adjusted capitation rates to provide all mandatory and optional services to Medicaid recipients.

The risk-adjusted capitation rates will be divided into sets of benefits: comprehensive benefits (those services needed by most recipients most of the time within a specific eligibility category) and catastrophic benefits (services for which the amount or cost exceeds a certain threshold). In addition, Medicaid recipients will be eligible for enhanced benefits accounts by following healthy lifestyle guidelines established by their managed care plan and approved by the agency (funds that can be used for benefits and services not covered by Medicaid). The proposal also includes an "opt-out" provision that allows a person to use the Medicaid capitation premium to purchase employer-sponsored health insurance instead of participating in a Medicaid managed care plan.

The proposal allows managed care plans to vary the amount, duration, and scope of services provided to Medicaid recipients enrolled in their plans within certain parameters deemed actuarially equivalent and sufficient by the state. Specifically, actuarial equivalence assesses the value of a particular managed care plan's proposed benefits compared to a target population's historical Medicaid expenditures to ensure the overall financial value of benefits is appropriate. Sufficiency to meet medical needs means whether the plan's proposed medical services will be provided at sufficient levels to serve a target population. A reform plan must cover the medical service needs of its target population. If a managed care plan fails to meet either the actuarial equivalency or sufficiency standards, the agency will not certify the plan until the benefits and services are adjusted to meet the necessary criteria.

In summary, the four fundamental elements of Florida's Medicaid reform program are as follows:

1) Risk-adjusted premiums that will be developed for Medicaid enrollees in managed care plans. The premium will have two components, comprehensive care and catastrophic care, and will be actuarially comparable to all services covered under the current Florida Medicaid program.

2) Enhanced Benefits Accounts will be established to provide incentives to Medicaid reform enrollees for healthy behaviors. As enrollees earn access to these incentives, funds will be deposited into individual Enhanced Benefits Accounts, and enrollees may use these funds to offset health-care-related costs, such as over-the-counter pharmaceuticals, vitamins, etc.

3) An Employer-Sponsored Insurance (ESI) option will provide individuals with the opportunity to use their premiums to "opt out" of Medicaid to purchase insurance through the workplace.

4) A Low-Income Pool (LIP) will be established and maintained by the state to provide direct payment and distributions to safety-net providers in the state for the purpose of providing coverage to the uninsured through provider access systems.

Through these fundamental elements, the reform initiative is expected to provide more recipient choice through greater competition among multiple managed care plans while promoting cost savings through better coordinated care, an increase in the use of preventive medicine, and a reduction in Medicaid fraud and abuse.

CS/CS/SB 838 (Medicaid Reform)

In response to the Governor's Medicaid reform proposal, the President of the Senate and the Speaker of the House of Representatives created Select Committees on Medicaid Reform in their respective chambers. The respective Select Committees met separately several times prior to and during the 2005 Regular Session. The Select Committees also held five joint public hearings in cities around the state, including Tampa, Ft. Lauderdale, Orlando, Panama City, and Jacksonville. During these meetings, the Select Committees heard testimony from hundreds of individuals including Medicaid recipients, health care providers, HMOs, advocacy groups, and other interested parties on ways to improve the Medicaid program. Committee members also met with stakeholders in one-on-one meetings during the Regular Session.

The Select Committees considered the ideas and suggestions from the various stakeholders and provided reform recommendations to their respective substantive committees that were included in bills in each chamber. The Legislature eventually passed a Medicaid Reform law in CS/CS/SB 838 (ch. 2005-133, L.O.F.). The provisions of the final bill offered opportunities to improve the current Medicaid program, while continuing a deliberative review of more comprehensive reform initiatives. As passed into law, CS/CS/SB 838 (2005) includes language:

- Authorizing and supporting the Office of the Governor and AHCA's efforts to develop and submit a waiver application to the federal government to implement the Governor's Medicaid reform proposal, including specific provisions and conditions that must be addressed in the waiver application.
- Requiring that any waiver approved by the federal government must preserve the upper payment limit (UPL) program with a reasonable growth factor (the upper payment limit cannot be used in a capitated managed care system because it is calculated with fee-for-service claims).
- Requiring that any federally-approved waivers and a detailed implementation plan are to be submitted to the Legislature for it to consider whether to approve implementation of the demonstration program.
- Requiring the first phase of the demonstration to be in Broward and Duval Counties, with an expansion into Baker, Clay, and Nassau Counties after the first year of implementation.
- Directing AHCA, in consultation with the Department of Elder Affairs, to redesign and implement an integrated managed long-term care system for persons over 60 years of age. The integrated system is to be pilot tested in two areas of the state with one pilot allowing voluntary participation and the other mandatory participation. The agency is to recommend the pilot sites.

Other provisions of the law expand AHCA's authority to deter, detect, and recover Medicaid funds lost to fraud and abuse; require AHCA to develop incentives for providers to reduce inappropriate utilization in the current system; require AHCA to develop and expand systems to share medical information in Medicaid; require AHCA to modify and expand its disease management programs; and require AHCA and the Office of Program Policy Analysis and Government Accountability (OPPAGA) to further study other ideas to improve Medicaid. Finally, the bill established a formal process for the Legislature to review any approved waivers prior to the agency moving forward with implementation of any federally approved waivers regarding reform.

The Federally-Approved Waivers and Special Terms and Conditions

The Agency for Health Care Administration complied with the provisions of CS/CS/SB 838 by posting the waiver application on its website 30 days before submitting it to the federal government and received approval of the waiver application on October 19, 2005. The federally-approved waivers are accompanied by special terms and conditions (numbered 11-W-00206/4) which, combined, constitute the guiding agreement between the state and federal government on the implementation of the Governor's Medicaid reform proposal.

The federally approved waivers and special terms and conditions are divided into 19 sections with 120 specific conditions, or items. The contents of each section are described below.

1. **PREFACE** – This section explains that the document comprises the special terms and conditions (STCs) for the Florida Medicaid Reform Section 1115 demonstration waiver and that the parties to this agreement are the Agency for Health Care Administration (Florida) and the U.S. Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. This demonstration is approved for a 5-year period, from July 1, 2006, through June 30, 2011.

2. **PROGRAM DESCRIPTION AND OBJECTIVES** – This section describes the fundamental concepts of the Medicaid reform proposal and the objectives that are to be attained through the demonstration.

3. **GENERAL PROGRAM REQUIREMENTS** – This section contains general program requirements that are included with most waivers including requirements for: compliance with federal laws, including non-discrimination; procedures for amending the approved STCs; extension of the demonstration program; procedures for phasing out the demonstration if either party elects to discontinue the program; and procedures to address non-compliance with the provisions of the waiver.

4. **GENERAL REPORTING REQUIREMENTS** – This section contains general reporting requirements that are routinely included in similar waivers including requirements for: general financial reports; reporting issues relating to budget neutrality; managed care data reports; quarterly progress reports; and annual progress reports.

5. **DEMONSTRATION IMPLEMENTATION** - This section specifies how the Medicaid reform initiative may be implemented in the state. It provides for implementation, which will be conducted in four phases, consistent with the requirements in CS/CS/SB 838.

   Phase I requires that the state will initially implement the demonstration in two counties, Broward and Duval, beginning sometime between July and September 2006. Within a year of implementation in Duval County, the state shall expand the demonstration into Baker, Clay, and Nassau Counties. Further implementation of Phases II through IV will be only as authorized by the Florida Legislature.

Phase II requires an assessment on the availability of plans, variation of plans, voluntary selection rates, consumer satisfaction, and on-site reviews of the plans authorized in Phase I. The preliminary fact-finding and evaluation of Phase I rollout will occur during the second year of operation, and will be complete by June 2008. This information will be available to the Legislature, and, once the agency receives approval, it will initiate implementation in additional geographic areas of the state.

Phase III will occur over the following two state fiscal years, with near or full geographic implementation of Medicaid Reform expected by June 2010. Phase III geographic expansion is targeted to culminate in Medicaid Reform plans being operational statewide. This will be accomplished in stages, again with mandatory and voluntary populations enrolled on a staggered basis. In addition, by Phase III the State expects that the special care networks for children with chronic conditions will be fully developed beyond the Broward and Duval areas, either on a limited or statewide basis. Enrollment of these children will become mandatory in those areas with such networks.

Phase IV of Medicaid reform implementation will occur once the geographic implementation is complete. This phase consists of expanding reform to additional populations, specifically by mandating the enrollment of those population groups previously enrolled voluntarily (see 6. below for example of these groups). The area-by-area roll out of each population may be different for different population groups, depending upon the availability of fully developed networks. Enrollment may be limited to those areas that were fully implemented by the end of Phase II, thus enabling those with the most experience under reform principles to be the initial sites for population expansion. The transition of these populations will also be on a staggered basis.

6. **ELIGIBILITY** - This section specifies which Medicaid eligibility populations will be included at what point during the demonstration. During the initial phase, participation in Medicaid reform will be mandatory for two eligibility groups currently covered by Florida Medicaid. The first group is the 1931 eligibles and related group, also referred to as the TANF and TANF-related eligibility group, and the second is the Aged and Disabled group (or SSI population). The above groups are mandatory Medicaid eligibles, with the exception of poverty level children up to age one with family income above 185 percent of FPL but below 200 percent of the federal poverty level (FPL).

   During the initial phase, individuals listed below may voluntarily participate in the demonstration. The state anticipates that during subsequent phases, individuals identified as voluntary in the groups below, as well as additional eligibility groups not included during the initial phase-in, will be mandated to participate in the demonstration. Specifically, children with chronic conditions participating in Children's Medical Services, foster care children and individuals with developmental disabilities will be required to participate in a reform program upon development and implementation of networks to meet their needs, as specified by the state Legislature.

   The following individuals eligible under the TANF and SSI groups listed below will be excluded from mandatory participation during the initial phase:

a. Foster care children will be a mandatory population no later than the end of demonstration year 3.
b. Individuals with developmental disabilities will be a mandatory population no later than the end of demonstration year 3.
c. Children with special health care needs will be a mandatory population no later than the end of demonstration year 3.
d. Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD (by year 5).
e. Individuals eligible under a hospice-related eligibility group (by year 5).
f. Pregnant women with incomes above the 1931 poverty level (by year 5).
g. Dual eligible individuals (by year 5).

The state is not obligated under this demonstration to extend eligibility to population groups listed above as voluntary populations, but may do so.

7. **ENROLLMENT** – This section describes the enrollment process that will be used to implement Medicaid reform. Within each geographic demonstration area the state will stagger the transition for enrollment of mandatory participants into the Medicaid reform demonstration. At the time of eligibility determination, individuals who are mandated to participate will receive information about managed care plan choices in their area. They will be informed of their option to select an authorized managed care plan or opt out of Medicaid. Individuals will be given the opportunity to meet with a choice counselor (either state-employed or state-designated) to obtain additional information in making a choice. If they opt out, they can use their Medicaid established premium to pay for employer-sponsored insurance, or private health insurance if they are self-employed. They will be required to select a plan or opt out within 30 days of eligibility determination. If the individual does not select a plan or opt out within the 30-day period, the state will auto-assign the individual into a Medicaid reform plan. Current Medicaid enrollees who are enrolled in a managed care plan or the MediPass program will be required to enroll in a reform plan at the time of their eligibility redetermination, or their open enrollment period, whichever is sooner.

   Once a mandatory enrollee has selected a Medicaid Reform Plan the enrollee shall be enrolled in the plan for a total of 12 months, which includes a 90-day disenrollment period. Once an individual is enrolled into a Medicaid reform plan the individual will have 90 days to voluntarily disenroll from that plan and select another plan. If an individual chooses to remain in the plan past 90 days the individual will remain in the selected plan for an additional nine months for a total enrollment period of 12 months, and no further changes may be made until the next open enrollment period except for cause.

8. **CHOICE COUNSELING** – This section describes the process that will be used to provide choice counseling to Medicaid recipients so they will be adequately informed of their options in order to choose a plan that best meets their health care needs. Specifically, the choice counselor will provide information on either selecting a reform plan or opting out of Medicaid. The choice counselor will provide information to individuals interested in opting out, explain the concept and reenrollment provisions and provide contact information regarding the administrator. The choice counselor will assist the individual in making an

informed choice about opt-out by highlighting information the individual will need to consider in order to make a fully informed choice.

As it does now, the state or the state's designated choice counselor will provide information about each plan's coverage in accordance with federal requirements. Additional information will include, but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. In addition, the state will supplement coverage information by providing performance information on each plan. The supplement information may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance data.

The state shall contract with an independent choice counselor to provide full and complete information about managed care plan choices and the ability to opt out of Medicaid. As directed by the state Legislature, the state will develop a choice counseling system that promotes and improves health literacy and provides information to reduce minority health disparities through outreach activities.

9. **BENEFIT PACKAGES AND MEDICAID REFORM PLANS** – This section specifies that Medicaid reform plans will have the flexibility to provide customized benefit packages for Medicaid reform enrollees. The customized benefit packages must cover all mandatory services specified in the state plan including medically necessary services for pregnant women and EPSDT services for children under age 21. In addition, the plans will cover needed optional services as indicated by historical data. However, the amount, duration and scope of all covered services, mandatory and optional, may vary to reflect the needs of the population. The plans authorized by the state shall not have service limits more restrictive than authorized in the state plan for children under the age of 21, pregnant women, and emergency services. The state may also capitate all state plan services in a demonstration area.

   The state will separate the Medicaid capitation premium into two components – comprehensive care and catastrophic care. The comprehensive care component includes the Medicaid services that the majority of Medicaid enrollees will need and is expected to represent approximately 90 percent of historical medical expenditures. The catastrophic care component is designed to meet the needs of the limited number of Medicaid enrollees who have unusually high costs in any particular year. For each target population served, the state will establish criteria to allow plans to choose whether or not to assume the catastrophic risk.

   All benefit packages must be prior-approved by the state and must be at least actuarially equivalent to the services provided to the target population under the current state plan benefit package. In addition the plan's customized benefit package must meet a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population.

   All health plans will be responsible for providing and coordinating all recipient benefits, regardless of whether those benefits are being funded through the comprehensive or catastrophic premium component and regardless of whether the plan has chosen to bear

financial risk for catastrophic care. For those plans that do not accept financial risk, the state becomes the re-insurer, and the health care plan remits claims to the state for services rendered under this component. The move from comprehensive to catastrophic is seamless for the enrollee, and the enrollee does not know which health plans are at risk for the catastrophic component.

The state will also establish an overall annual maximum benefit level in conjunction with the development of the premium components. The maximum benefit limit will be applied to all reform recipients with the exception of children under age 21 and pregnant women. The annual aggregate maximum limit provides a safeguard to enrollees, as the annual limit will renew each year to cover additional services.

10. **EMPLOYER SPONSORED INSURANCE/OPT-OUT PROVISION** – This section describes the opt-out provision which allows a Medicaid recipient to use the capitation premium to acquire employer-sponsored insurance (ESI). If a person elects the opt-out provision, the state shall provide the employee share but no more than the Medicaid authorized premium. If the employee contribution for the ESI plan exceeds the Medicaid authorized premium, then the enrollee will be responsible for paying the additional amount. If the employee contribution is less than the Medicaid authorized premium, the enrollee may use the remainder of the premium to purchase family coverage or purchase supplemental health insurance coverage offered by the employer. The state may limit payment for supplemental policies to ensure efficient use of premium dollars. The availability of supplemental policies may provide access to services not currently covered by Medicaid such as adult dental coverage.

11. **ENHANCED BENEFIT ACCOUNTS** – This section describes the establishment and access to the enhanced benefit accounts. Enhanced Benefits Accounts (EBA) will be established to provide incentives to Medicaid reform enrollees for participating in state-defined activities that promote healthy behaviors. All enrollees in a Medicaid reform plan, including mandatory and voluntary enrollees, will be eligible to participate in activities to earn enhanced benefits for the duration of their enrollment. An individual who participates in a state-defined activity that promotes healthy behavior shall have funds deposited into the individual EBA. These funds shall be used for health care related expenditures as defined in Section 1905 of the Social Security Act. Regardless of the reason for the loss of eligibility to participate in the demonstration, an individual may retain access to any earned funds for a maximum of 3 years, so long as, the individual's income is below 200 percent of the federal poverty level (FPL).

12. **RECIPIENT COST SHARING** – This section establishes allowable cost-sharing requirements for specific services. It also states that individuals who select to opt out of Medicaid are subject to any cost sharing requirements in their employer's benefit plan.

13. **DELIVERY SYSTEM** – This section establishes criteria for which plans may participate in the reform demonstration; requires managed care plans to contract with Federally Qualified Health Centers (FQHCs), County Health Departments (CHDs), and Rural Health Centers (RHCs), or to demonstrate that the plan has adequate network capacity if the plan does not

contract with these entities in their service area; and requires the state to evaluate its benefit evaluation model to verify actuarial equivalence and sufficiency on an annual basis.

14. **EVALUATION** - This section requires the state to develop an evaluation design that shall include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population and capitated revenue expenditures for the demonstration waiver. The evaluation design shall discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design shall identify whether the state shall conduct the evaluation, or select an outside contractor for the evaluation. This design must be submitted to the federal government for approval by February 2006.

15. **LOW INCOME POOL** – This section creates the low income pool (LIP) as a replacement for the hospital upper payment (UPL) program. The LIP will be established to ensure continued government support for the provision of health care services to Medicaid, underinsured, and uninsured populations. The LIP consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period.

    Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Social Security Act. These health care expenditures may be incurred by the state, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the state and the federal CMS.

    Funds in the LIP will become available upon implementation of Florida Medicaid Reform, which shall be no later than July 1, 2006, provided the pre-implementation milestones are met as discussed below in Section XVI "Low Income Pool Milestones." In order to define LIP permissible expenditures the state shall submit for CMS approval a Reimbursement and Funding Methodology document for the LIP expenditures and LIP parameters defining state-authorized expenditures from the LIP and entities eligible to receive reimbursement. This document must be submitted to the federal government by March 2006.

16. **LOW INCOME POOL MILESTONES** – This section describes the milestones that must be met by the state for each year of the demonstration in order to access the total $1 billion annual allocation of LIP funds. Each year of the demonstration includes specific milestones, including five significant milestones that must be achieved before July 1, 2006, in order to transition from the current hospital UPL program to the new LIP program.

17. **OTHER DEMONSTRATION MILESTONES** – This section cross references other milestones for the reform waiver in general that are included throughout the federally-approved special terms and conditions.

18. **GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX (MEDICAID)** – This section specifies how the budget neutrality agreement is established and the reporting requirements necessary to verify expenditures under the reform demonstration.

19. **MONITORING BUDGET NEUTRALITY** – This section describes the budget neutrality monitoring process, or how the federal government will determine whether the state is spending equal to or less than what it was expected to spend in its Medicaid program without this reform waiver.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.911, F.S., creating the Medicaid Low-Income Pool Council; providing for membership and duties of the Council; and abolishing the current Medicaid Disproportionate Share Council.

Section 2. Amends s. 409.912, F.S., authorizing AHCA to contract with comprehensive behavioral health plans in separate counties within or adjacent to an AHCA area in order to prevent a conflict with the Medicaid reform pilot program; conforming provisions to the solvency requirements in s. 641.2261, F.S., for provider service networks; deleting the competitive-procurement requirement for provider service networks; and updating a reference to the provider service network.

Section 3. Amends s. 409.91211, F.S., to:

- Specify the process for statewide expansion of the Medicaid managed care demonstration program;
- Require that matching funds for the Medicaid UPL/LIP program be provided by local governmental entities;
- Provide for distribution of low income pool funds by the agency;
- Provide legislative intent with respect to the low-income pool plan required under the Medicaid reform waiver;
- Specify the agency's powers, duties, and responsibilities with respect to implementing the Medicaid managed care pilot program;
- Revise the guidelines for allowing a provider service network to receive fee-for-service payments in the demonstration areas;
- Authorize the agency to make direct payments to hospitals and physicians for the costs associated with graduate medical education under Medicaid reform;
- Include the Children's Medical Services Network in the Department of Health within those programs intended by the Legislature to participate in the pilot program to the extent possible;
- Require that the agency implement standards of quality assurance and performance improvement in the demonstration areas of the pilot program;
- Require the agency to establish a patient encounter database to compile data from managed care plans;

- Require the agency to implement procedures to minimize the risk of Medicaid fraud and abuse in all managed care plans in the demonstration areas;
- Clarify that the assignment process for the pilot program is exempt from certain mandatory procedures for Medicaid managed care enrollment specified in s. 409.9122, F.S.;
- Revise the automatic assignment process in the demonstration areas; requiring that the agency report any modifications to the approved waiver and special terms and conditions to the Legislature within specified time periods;
- Authorize the agency to implement the provisions of the waiver approved by the federal Centers for Medicare and Medicaid Services; and
- Provide that, if any conflict exists between the provisions contained in s. 409.91211, F.S., and ch. 409, F.S., concerning the implementation of the pilot program, the provisions contained in s. 409.91211, F.S., control.

Section 4. Creates s. 409.91213, F.S., requiring the agency to submit quarterly and annual progress reports to the Legislature and requiring certain provisions to be included in the quarterly and annual reports.

Section 5. Amends s. 641.2261, F.S., updating a reference to federal solvency requirements for managed care organizations and revising the application of solvency requirements to include Medicaid provider service networks.

Section 6. Creates an undesignated section in law requiring that the agency report to the Legislature the pre-implementation milestones concerning the low income pool which have been approved by the federal government and the status of those milestones remaining to be approved.

Section 7. Provides an effective date of upon becoming a law.

IV. Constitutional Issues:

1. Municipality/County Mandates Restrictions:

   The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

2. Public Records/Open Meetings Issues:

   The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, s. 24(a) and (b) of the Florida Constitution.

3. Trust Funds Restrictions:

   The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

1. Tax/Fee Issues:

None.

2. Private Sector Impact:

The bill authorizes the implementation of the Medicaid reform pilot program as specified in s. 409.91211, F.S. One of the provisions allows for Medicaid recipients to opt out of the Medicaid program and use their capitated premium to purchase employer-sponsored insurance. This may allow more individuals to be covered through their employers which would increase the size of the private-sector risk pools, which could reduce the rate of growth in premiums for those plans. Since it is unknown how many people will choose the opt-out provision, the actual fiscal effect on the private insurance market is unknown.

3. Government Sector Impact:

CS/CS/SB 838 required AHCA to submit a Medicaid reform implementation plan to the Legislature, as a whole, for consideration in making a decision on approval of implementation of the waiver. The implementation plan was to include a timeline for implementation of the waiver and budgetary projections for 5 years (FY 2006-07 through FY 2010-2011).

The agency submitted The Florida Medicaid Reform Implementation Plan dated November 28, 2005, that reflects the budget neutrality estimates included in the federally approved reform waiver. Budget neutrality was estimated based on statewide implementation.

The budget neutrality estimates for Medicaid services reflect savings ranging from $190.8 million ($78.6 million general revenue) in FY 2006-2007 to $938.9 million ($386.8 million general revenue) in FY 2010-2011. Additional administrative expenditures of $15 million will be required in FY 2006-2007 per the Agency FY 2006-07 Legislative Budget Request for choice counseling, enhanced benefit accounts, management of employer sponsored insurance, premium development, evaluation and surveys, and infrastructure and system modifications.

CS/CS/SB 838 requires the Office of Program Policy Analysis and Government Accountability to submit an evaluation of the pilot programs (Broward and Duval counties), that includes cost savings, to the legislature no later than June 30, 2008.

Estimates in Millions

*Medicaid Services:	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
Estimated Expenditures Under Current Medicaid Program	$8,005.38	$9,074.63	$10,317.42	$11,763.27	$13,446.86
Estimated Expenditures Under Reform	$7,814.62	$8,747.05	$9,823.41	$11,067.67	$12,507.99
Projected Savings:	$190.76	$327.58	$494.01	$695.59	$938.87
General Revenue	*$78.59*	*$134.96*	*$203.53*	*$286.58*	*$386.81*
Trust Funds	*$112.17*	*$192.62*	*$290.48*	*$409.01*	*$552.05*

*Fiscal estimates based on budget projections as provided in the federal waiver and the agency's implementation plan submitted to the legislature on November 28, 2005.

Estimates in Millions

*Administrative Expenditures:	FY 2006-07	FY 2007-08**	FY 2008-09***	FY 2009-10***	FY 2010-11***
Choice Counseling	$6.50	$16.25			
Plan Evaluation/Satisfaction Survey	$0.50	$1.25			
Premium Development	$2.00	$5.00			
Enhanced Benefit Accounts	$3.00	$7.50			
Management of Employer Sponsored Insurance	$2.00	$5.00			
Infrastructure & System Modification	$1.00	$2.50			
Sub-Total Administrative Expenses	$15.00	$37.50			
General Revenue	*$7.50*	*$18.75*			
Trust Funds	*$7.50*	*$18.75*			

* Administrative expenditures for FY 2006-07 as listed in the agency's FY 2006-07 legislative budget request.
** Section 409.91211(1), F.S., allows the agency to expand reform into Baker, Clay and Nassau counties within one year after implementation in the initial two pilot counties. The FY 2007-08 administration estimates assume the per county administration expenses will remain the same as additional counties are added (Baker, Clay & Nassau).
*** Administrative costs are indeterminable

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.

COMPARISON OF SPECIAL SESSION MEDICAID BILLS (HB 3B AND SB 2B) (12/03/2005)		
HB 3B	**SB 2B**	**COMMENTS**
Section 1 (page 3) – Amends s. 641.2261, F.S., to specify solvency requirements for Medicare and Medicaid provider service organizations/networks.	See **Section 5** (pages 39 and 40) – Same as HB 3B, except for minor bill drafting differences.	
Section 2 (pages 4 and 5) - Amends s. 409.911(9), F.S., to create the Medicaid Low Income Pool Council and to abolish the Medicaid Disproportionate Share Council.	See **Section 1** (pages 3 – 5) –Only substantive difference is that (9)(a) does not include making recommendations on the financing of the upper payment limit program.	
Section 3 (pages 5 – 15) – On pages 9 - 12, amends s. 409.912(4)(b), F.S., to provide an exception from certain contract requirements for managed comprehensive behavioral services in Medicaid reform pilot areas. (Is struck through language on page 12, lines 305-309, a substantive change?) On page 14, amends s. 409.912(4)(d), F.S., to require certain solvency requirements for provider service networks and repeals the requirement for AHCA to competitively bid contracts with provider service networks.)	See **Section 2** (pages 5 – 14) – On pages 8 -11, same as HB 3B, except for minor bill drafting differences. (SB 2B does not strike through the language that is struck through on lines 305-309 in HB 3B) On page 13, same as HB 3B, except for minor bill drafting differences.	

HB 3B	SB 2B	COMMENTS
Section 4 (pages 15 – 40) – Amends s. 409.91211, F.S., relating to the Medicaid managed care pilot program.	**Section 3** (pages 14 – 37) – Amends s. 409.91211, F.S., relating to the Medicaid managed care pilot program.	
Not in HB 3B	On pages 14 and 15, amends (1)(a) to provide for statewide expansion of the Medicaid reform program in accordance with the federally-approved special terms and conditions.	
On page 16, amends (1)(a) to repeal language that requires a state evaluation of the pilot projects and legislative approval of statewide phase-in to additional counties.	Current statutory language is maintained.	
On page 16, amends (1)(a) to specify that state matching funds for UPL/LIP/DSH shall be provided by the state and local governmental entities through intergovernmental transfers and specifies that distribution of UPL/LIP/DSH funds be in accordance with federal requirements.	On page 15, amends (1)(b), but does not refer to the state providing matching funds. Distribution of funds the same as HB 3B, except for bill drafting differences.	
On pages 16 and 17, creates (1)(b) to establish objectives for the distribution of funds from the low income pool.	On pages 15 and 16, same as HB 3B, except for minor bill drafting differences.	
See subsection (8) on pages 39 and 40 – same as SB 2B, except for bill drafting differences.	On page 17, amends (2)(a) to define "capitated managed care plan".	

HB 3B	SB 2B	COMMENTS
On pages 18 – 32, amends (3) to generally authorize AHCA to implement, rather than develop and recommend, the pilot projects.	On pages 17 – 31, same as HB 3B, except for minor bill drafting differences.	
On page 19, amends (3)(c) to authorize AHCA to seek options for making direct payments for costs associated with graduate medical education.	On page 18, same as HB 3B.	
On pages 19 and 20, amends (3)(e) to require a savings-settlement mechanism for provider service networks paid fee-for-service rates.	On pages 18 and 19, same as HB 3B, except for minor fill drafting differences.	
On page 20, amends (3)(h) to include the Children's Medical Services Network in the list of providers which managed care plans in the pilot program should try to include in their networks.	On page 19, same as HB 3B, except for minor bill drafting differences.	
On pages 24 – 26, adds (3) (p), (q), (r), (s), and (t) to specify quality assurance and outcome measures and patient-encounter reporting requirements for managed care plans in the pilot project.	On pages 23 – 25, substantively the same as HB 3B, but bill drafting format is different.	
On page 27, amends (w) to delete the requirement that capitated managed care plans follow national guidelines for selecting health care providers.	On page 26, same as HB 3B.	
On pages 28 – 29, adds (3)(aa), to specify requirements to minimize the risk of Medicaid fraud and abuse in the pilot projects.	On pages 26 and 27, adds (3)(w) – same as HB 3B, except for minor bill drafting differences.	

HB 3B	SB 2B	COMMENTS
On pages 33 and 34, adds (4)(c) to clarify the auto assignment of Medicaid recipients currently enrolled in a Medicaid managed care plan.	On page 32, same as HB 3B, except for minor bill drafting differences.	
On page 36, repeals (5), which requires legislative approval of expansion of the pilot projects.	SB 2B maintains current statute.	
On pages 37 and 38, amends current (6) to authorize implementation of the pilot projects in accordance with the federally-approved special terms and conditions and to require notification of the Legislature for any proposed modifications to the special terms and conditions and any federally-approved modifications.	On page 36, same as HB 3B, except for minor bill drafting differences.	
On pages 38 and 39, adds a new (7) to require the Office of Insurance Regulation to review the Medicaid managed care pilot program's risk-adjusted rate setting methodology as developed by AHCA.	Not in SB 2B.	
See Section 10 of HB 3B – same as SB 2B, except for bill drafting differences.	On pages 36 and 37, adds a new (8) to provide legislative intent regarding any conflicts between s. 409.91211, F.S. (pilot projects) and the rest of chapter 409, F.S., relating to Medicaid and to require reports about statutory conflicts to the Legislature.	

HB 3B	SB 2B	COMMENTS
On pages 39 and 40, adds a new (8) to define "capitated managed care plan".	On page 17, same as HB 3B, except for bill drafting differences.	
Section 5 (pages 40 and 41) – Creates s. 409.91212, F.S., to establish the Joint Legislative Committee on Medicaid Reform Implementation and a process for the Committee to review AHCA requests for expansion against specified "readiness" criteria.	Not in SB 2B	
Section 6 (pages 42 – 47) – Amends s. 409.9122, F.S., to repeal the 60/40 ratio for auto assignment of Medicaid recipients into managed care vs. MediPass.	Not in SB 2B.	
Section 7 (page 47) – Requires AHCA to report to the Legislature by April 1, 2006, regarding the low-income pool preimplementation milestones required by the federal government.	See **Section 6** of SB 2B (page 40) – same as HB 3B, except for bill drafting differences.	
Section 8 (pages 47-50) – Establishes quarterly and annual implementation progress reports from AHCA to the Legislature.	See **Section 4** of SB 2B (pages 37 – 39) – same as HB 3B, except for bill drafting/formatting differences.	

HB 3B	SB 2B	COMMENTS
Section 9 (pages 50 – 52) – Creates s. 11.72, F.S., to establish the Joint Legislative Committee on Medicaid Reform Implementation and specifies the membership, powers, and duties of the Committee.	Not in SB 2B	
Section 10 (pages 52 and 53) - Provides legislative intent regarding any conflicts between s. 409.91211, F.S. (pilot projects) and the rest of chapter 409, F.S., relating to Medicaid and to require reports about statutory conflicts to the Legislature.	See pages 36 and 37, same as HB 3B, except for bill drafting differences.	
Section 11 (page 53) – Amends s. 216.346, F.S., to modify requirements related to overhead or indirect costs in contracts between state agencies to allow federal Medicaid funds to be passed on to other state agencies by contract.	Not in SB 2B.	
Section 12 (page 53 and 54) – Provides an appropriation to the Office of Insurance Regulation to review the Medicaid managed care pilot program's risk adjusted rate setting methodology.	Not in SB 2B.	

HB 3B	SB 2B	COMMENTS
Section 13 (page 54) – Provides an effective date of upon becoming a law.	Section 7 (page 40) – same as HB 3B.	

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable Jeb Bush
Governor of Florida
Tallahassee, FL 32399-0001

OCT 19 2005

Dear Governor Bush:

I am pleased to inform you that Florida's Section 1115 demonstration application entitled "Florida Medicaid Reform" is approved today for a period of five years. On this historic day you now have authority to embark upon next steps to begin a demonstration that may serve as a model for national reform of the Medicaid Program.

Under Florida's reform plan, the State will test important innovations and provide a model for delivering health care services to some of America's neediest individuals in the twenty-first century. Florida will modernize its health care delivery system by increasing the number of individuals in premium based managed care programs. The state will also be putting the beneficiary "in the driver's seat": Medicaid consumers will have a choice of plans and a variety of benefit packages from which to choose.

My Department looks forward to working with your staff as Florida implements the other significant program changes under the demonstration, including the establishment of enhanced benefit accounts; improved access to employer sponsored insurance; and the implementation of a Low Income Pool to provide services to uninsured individuals.

Approval of the Florida Medicaid Reform Section 1115(a)(1) demonstration, including the waivers and expenditure authorities provided to enable the state to implement this important project, is conditioned upon acceptance and compliance with the Special Terms and Conditions that will accompany the final approval package.

I am sure you are proud of your team, including Alan Levine, Nina Oviedo, Carol Gormley, Karen Hogan, Tom Arnold, Dyke Snipes, Roberta Kelley and Robert Butler and all of the others who worked so diligently to represent the interests of Floridians. They are a topnotch staff and demonstrated extraordinary dedication and professionalism during the negotiation process with my staff.

Again, congratulations on the upcoming implementation of the Florida Medicaid Reform demonstration. I look forward to continuing to work in partnership with you to realize our shared objective of providing high quality cost-effective care to low-income and disabled and elderly Americans.

Sincerely,

Michael O. Leavitt

WAIVER AUTHORITIES FOR FLORIDA'S MEDICAID REFORM SECTION 1115 DEMONSTRATION

NUMBER: **11-W-00206/4**

TITLE: **Florida Medicaid Reform Section 1115 Demonstration**

AWARDEE: **Agency for Health Care Administration**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning July 1, 2006, through June 30, 2011.

The following waivers shall enable the State to implement the approved Special Terms and Conditions (STCs) for the Florida Medicaid Reform section 1115 Demonstration.

Title XIX Waivers

1. Statewideness/Uniformity **Section 1902(a)(1)**

To enable Florida to operate the demonstration and provide managed care plans or certain types of managed care plans, including provider sponsored networks, only in certain geographical areas.

2. Amount, Duration, and Scope and Comparability **Section 1902(a)(10)(B)**

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements and to permit Florida to offer different benefits to demonstration populations one and two than to the categorically needy group.

3. Income and Resource Test **Section 1902(a)(10)(C)(i)**

To enable Florida to exclude funds in an enhanced benefit account from the income and resource tests established under State and Federal law for purposes of determining Medicaid eligibility. Beneficiaries will also be permitted to accumulate financial resources in a separate account for special approved services.

4. Cost Sharing **Section 1902(a)(14) insofar as it incorporates Section 1916**

To enable Florida to authorize coverage of employer-based or private plans that have cost sharing requirements for participants covered under the demonstration in excess of statutory limits.

5. Freedom of Choice **Section 1902(a)(23)**

To enable Florida to restrict the freedom of choice of providers.

6. Provider Agreements **Section 1902(a)(27)**

To permit the provision of care by entities who have not executed a provider agreement with the State Medicaid Agency for the purpose of providing enhanced benefits to beneficiaries for authorized expenditures under the enhanced benefits account.

7. Retroactive Eligibility **Section 1902(a)(34)**

To enable Florida to waive the requirement to provide medical assistance for up to 3 months prior to the date that the application for assistance is made.

8. Eligibility **Section 1902(a)(10)(A)**

To allow the State to provide only emergency medical services and nursing home level of care for up to 30 days from the time the applicant is determined eligible until the newly eligible beneficiary selects a managed care plan or is automatically enrolled into a managed care plan.

To allow the State to not provide Medicaid covered State plan services for individuals who voluntarily elect to opt out of Medicaid into an employer sponsored insurance program or private health plan for the duration of the individual's voluntary enrollment into the plans covered outside the parameters of the demonstration.

9. Payment Review **1902(a)(37)(B)**

To the extent that prepayment review may not be available for disbursements by individual beneficiaries to their providers.

EXPENDITURE AUTHORITY
FOR FLORIDA'S MEDICAID REFORM
SECTION 1115 DEMONSTRATION

NUMBER: **11-W-00206/4**

TITLE: **Florida Medicaid Reform Section 1115 Demonstration**

AWARDEE: **Agency for Health Care Administration**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this demonstration July 1, 2006, through June 30, 2011, be regarded as expenditures under the State's Title XIX plan.

The following costs not otherwise matchable expenditure authories shall enable the State to implement the approved Special Terms and Conditions (STCs) for the Florida Medicaid Reform section 1115 Demonstration.

1. **Demonstration Population 1.** Expenditures for employee costs of authorized employer-sponsored individual or family insurance coverage for individuals who would be eligible under the State plan but have elected not to apply under the State Plan, or expenditures for the costs of an authorized private plan for such individuals who are self employed, not to exceed the amount that would be expended as the State-established premium under this demonstration for individuals eligible under the State Plan.

2. **Demonstration Population 2.** Expenditures for health care related costs under enhanced benefit accounts for individuals who lose eligibility for Medicaid or demonstration population 1 benefits, with incomes at or below 200 percent of the Federal poverty level. This expansion population shall be allowed to retain access to the enhanced benefit account for up to p years, except in the instance of termination of the demonstration or the enhanced benefit accounts provision under the demonstration.

3. Expenditures for costs incurred as a result of the automatic re-enrollment, in the last plan of enrollment, for enrollees who have regained eligibility within six months, and which would not otherwise be eligible for automatic re-enrollment under Section 1903(m)(2)(H) of the Act.

4. Expenditures made by Florida for costs related to providing health care services to uninsured and or underinsured, subject to the restrictions placed on the Low Income Pool, as defined in the STCs.

5. Expenditures for enhanced benefits accounts.

Medicaid Requirements Not Applicable to the Expenditure Authorities:

In order to permit the demonstration project to function as amended, in addition to and/or consistent with previously approved waiver and expenditure authorities described above, the following Medicaid requirements are not applicable to the Expenditure Authorities:

1. **Provision of Medical Assistance** **Section 1902(a)(10)(A)**

   To enable Florida to limit the medical assistance for demonstration populations 1 and 2 available to the types of assistance described in these expenditure authorities.

2. **Amount, Duration, Scope and Comparability of Benefits** **Section 1902(a)(10)(B)**

   To enable Florida to vary the amount, duration, and scope of benefits offered to demonstration populations 1 and 2 from that offered to other beneficiaries under the plan, and to enable those benefits to be non-comparable to those offered to the categorically needy group.

3. **Provider Agreements** **Section 1902(a)(27)**

   To permit the provision of care by entities who have not executed a provider agreement with the State Medicaid Agency for the purpose of providing enhanced benefits to beneficiaries for authorized expenditures under the enhanced benefits account.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00206/4**

TITLE: **Medicaid Reform Section 1115 Demonstration**

AWARDEE: **Agency for Health Care Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Florida Medicaid Reform section 1115 demonstration (hereinafter "demonstration"). The parties to this agreement are the Agency for Health Care Administration (Florida) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the State's obligations to CMS during the life of the Demonstration. This demonstration is approved for a 5-year period, from July 1, 2006, through June 30, 2011.

The STCs have been arranged into the following subject areas: General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits and Coverage; Cost Sharing; Delivery Systems; Evaluation; Low Income Pool Definitions; Low Income Pool Milestones; General Financial Requirements under title XIX; and Monitoring Budget Neutrality.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Florida Medicaid Reform section 1115 demonstration, the State's role will change so that it is largely a purchaser of care, and oversight will focus on improving access and increasing quality of care. Medicaid consumers will have a choice in the marketplace and will be able to choose plans and the methods of accessing services.

The State proposes to transform Medicaid by integrating key principles of reform in the structure and daily operation of the Medicaid program as follows:

> *Patient Responsibility and Empowerment* – With the support of choice counselors, individuals will then be expected to take an active role in their health care. They will have the flexibility to choose from a variety of benefit packages and be able to choose the package that best meets their needs. Additionally, they will be rewarded for demonstrating healthy practices and personal responsibility.
>
> *Marketplace Decisions* – The State will reshape its role in health care from that of a centralized decision maker that creates and manages health care services to a purchaser of health care services responsible for ensuring the systems of care delivery meet the higher standards and follow the rules for ensuring delivery of quality services. Managed care

plans will have the ability to create customized packages to meet the needs of specific Medicaid groups.

Bridging Public and Private Coverage – Individuals with access to employer-sponsored insurance (ESI) coverage will be offered the choice to "opt out" of Medicaid. This choice will help bridge the gap to independence by providing individuals with a subsidy to move to private health insurance coverage.

Sustainable Growth Rate – Medicaid will move to a premium-based system and Medicaid expenditures will become more predictable.

The four fundamental elements of Florida Medicaid Reform are as follows:

Risk-Adjusted Premiums will be developed for Medicaid enrollees in managed care plans. The premium will have two components, comprehensive care and catastrophic care, and will be actuarially comparable to all services covered under the current Florida Medicaid program.
Enhanced Benefits Accounts will be established to provide incentives to Medicaid Reform enrollees for healthy behaviors. As enrollees earn access to these incentives, funds will be deposited into individual Enhanced Benefits Accounts, and enrollees may use these funds to offset health-care-related costs, such as over-the-counter pharmaceuticals, vitamins etc.
Employer-Sponsored Insurance (ESI) option will provide individuals with the opportunity to use their premiums to "opt out" of Medicaid to purchase insurance through the workplace.
Low-Income Pool (LIP) will be established and maintained by the state to provide direct payment and distributions to safety net providers in the state for the purpose of providing coverage to the uninsured through provider access systems.

Under this demonstration Florida expects to achieve the following objectives.

- Introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost.
- Increase the number of individuals in a capitated or premium-based managed care program and reduce the number of individuals in a fee-for-service program.
- Improve health outcomes and reduce inappropriate utilization.
- Demonstrate that by moving most recipients into a coordinated care-managed environment, the overall health of Florida's most vulnerable citizens will improve.
- Serve as an effective deterrent against fraud and abuse by moving from fee-for-services.
- Maintain strict oversight of managed care plans and will adapt its fraud efforts to surveillance of fraud and abuse within the managed care system.
- Provide managed care plans with additional flexibility in creating benefit packages to meet the needs of specific groups.
- Provide plans the ability to substitute services and cover services that would otherwise not be covered by traditional Medicaid.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid Program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Demonstration.

3. **Changes in Law**. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid Program that occur after the approval date of this Demonstration.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate such changes into a modified budget neutrality expenditure cap for the demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State shall not be required to submit Title XIX State Plan amendments for changes to any populations covered solely through the demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required, except otherwise noted in the terms and conditions. Reimbursement of providers by the MCO will not be limited to those described in the State Plan.

6. **Changes Subject to the Demonstration Amendment Process.** Changes related to eligibility, enrollment, auto-enrollment benefits, cost sharing, employer sponsored insurance, implementation changes, Low Income Pool, Federal financial participation (FFP), sources of the non-Federal share, budget neutrality, and other comparable program and budget elements must be submitted to CMS as amendments to the demonstration. The State agrees it will submit an amendment to the demonstration prior to adding dual eligible individuals; hospice and hospice-related groups, and individuals eligible, as Medically Needy. The State shall not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the Demonstration that

have not been approved through the amendment process set forth in paragraph 7, below.

7. **Amendment Process.** Amendment requests must be submitted to CMS for approval no later than 120 days prior to the date of implementation and may not be implemented until approved. Amendment requests shall be reviewed by the Federal review team and must include but are not limited to the following:

a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
b) A current assessment, including necessary expenditure data, of the impact the requested amendment shall have on budget neutrality;
c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
d) A description of how the evaluation design shall be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** If the State intends to extend the Demonstration beyond the period of approval granted herein Section 1115(a) of the Social Security Act (the Act), the State is then responsible for reviewing, complying and adhering to the timeframes and reporting requirements as stated in Section 1115(a), 1115(e) or 1115(f) of the Act as applicable.

9. **Demonstration Phase-Out.** The State may suspend or terminate this demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State shall submit a phase-out plan to CMS, for approval, at least 6 months prior to initiating phase out activities. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. If the project is terminated or any relevant waivers suspended by the State, FFP shall be available for only normal close out costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **Enhanced Benefit Accounts Program Phase Out.** The State shall submit a phase-out plan to CMS for approval no later than 6 months prior to any such time the State proposes to terminate the enhanced benefit account (EBA) provision of this demonstration.

The Enhanced Benefit Accounts Program will be limited as follows:

- Enrollees will not be able to earn enhanced benefits for deposit into their account during the last 3 months of the demonstration or the termination of the EBA Provision under the demonstration; and

- Individuals, who previously earned funds in their EBA, will continue to have

access to funds for health care related expenditures in accordance with EBA rules. All funds must be expended within a 2-year period from the expiration date of the demonstration.

- The Federal share of any unspent funds shall be returned to CMS no later than the end of the first quarter after, which ends the 2-year period above.

11. **Enrollment Limitation.** During the last 6 months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current State plan shall not be permitted unless the demonstration is extended by CMS.

12. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing at which it has been determined that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

13. **Finding of Non-Compliance.** The State waives none of its rights to challenge CMS's finding that the State materially failed to comply.

14. **Withdrawal of Waiver or Expenditure Authority**. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. If a waiver or expenditure authority is withdrawn, FFP shall be available for only normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

15. **Adequacy of Infrastructure.** The State shall ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing; and reporting on financial and other Demonstration components.

16. **Public Notice and Consultation with Interested Parties.** The State shall comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (1994) when any program changes to the Demonstration are proposed by the State.

17. **Managed Care Requirements**. The State must comply with the managed care regulations published at 42 CFR 438. Capitation rates, including both components of the comprehensive and catastrophic components, shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan services used in the rate development process.

IV. GENERAL REPORTING REQUIREMENTS

18. **General Financial Reporting Requirements.** The State shall comply with all

general financial reporting requirements set forth in Section XVIII, "General Reporting Requirements under Title XIX."

19. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality set forth in Section XIX, "Monitoring Budget Neutrality."

20. **Managed Care Data Requirements.** All managed care organizations, prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs) shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438.

21. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, the benefit package, enhanced benefit accounts program, choice counseling activities, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

22. **Quarterly Reports.** The State shall submit progress reports no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of various operational areas. Quarterly reports shall include but are not limited to the following:

    a) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues.
    b) Action plans for addressing any policy and administrative issues.
    c) State efforts related to the collection and verification of encounter data, and utilization data.
    d) Enrollment data disaggregated by plan and by the following specifications: eligibility category, TANF or SSI, total number of enrollees; market share; and percentage change in enrollment by plan. In addition, the State will provide a summary of voluntary and mandatory selection rates and disenrollment data.
    e) For purposes of monitoring budget neutrality the quarterly reports shall include enrollment data, member month data, and expenditures in the budget neutrality-monitoring format provided by CMS.
    f) Low Income Pool activities and associated expenditures.

g) Activities related to the implementation of choice counseling including efforts to improve health literacy and the methods used to obtain public input including recipient focus groups.
h) Participation rates in the Enhanced Benefit Accounts Program. This shall include: participation levels; summary of activities and the associated expenditures; number of accounts established including active participants and individuals who continue to retain access to funds in an account but no longer actively participate; estimated quarterly deposits in accounts, and expenditures from the account.
i) Enrollment Data on employer sponsored insurance (ESI) that documents the number of individuals selecting to opt-out when ESI is available. The State shall include data that will identify enrollee characteristics as follows: 1) eligibility category; 2) type of employer-sponsored insurance (e.g., small employer, large employer, ERISA); 3) type of coverage – single or family coverage. The State will develop and maintain disenrollment reports specifying the reason for disenrolling in an ESI program. The State shall also track and report on those enrollees who elect the option to reenroll in the Medicaid Reform demonstration.
j) Progress toward the demonstration goals.
k) Evaluation activities.

23. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted to CMS.

Beginning with the annual report for demonstration year 2, the State must include a section on the administration of Enhanced Benefit Accounts, participation rates, an assessment of expenditures, and potential cost savings.

Beginning with the annual report for demonstration year four, the State must include a section that provides qualitative and quantitative data that describes the impact the Low Income Pool had on the rate of uninsurance in Florida starting with the implementation of the demonstration.

V. FLORIDA MEDICAID REFORM DEMONSTRATION IMPLEMENTATION

24. **Florida Legislation SB 838.** The State will implement the Medicaid Reform demonstration in three phases. The State shall notify CMS 90 days prior to any geographic expansion prior to submission of a statewide implementation plan as required in item 100. The State will submit any required amendments in accordance with paragraphs six and seven in Section III, "General Program Requirements."

25. **Implementation of Phase I.** The State will initially implement the Medicaid Reform demonstration in two counties Broward and Duval. Reform shall become operational in the first quarter of state fiscal year (SFY) 2007, which is July through September 2006.

Within a year of implementation in Duval County, the State shall expand the demonstration to include three contiguous counties to Duval County: Baker, Clay and Nassau Counties. The State expects this to be operational by July 2007.

Further implementation of Phase II and Phase III will be only as authorized by the Florida State Legislature.

26. **Implementation of Phase II.** The State will begin preliminary assessments on availability of plans, variation of plans, voluntary selection rates, consumer satisfaction and perform on-site reviews of the plans authorized in Phase I. The preliminary fact-finding and evaluation of Phase I rollout will occur during the second year of operation, and will be complete by June 2008. This information will be available to the Legislature, and, once the Agency receives approval, it will initiate implementation in additional geographic areas of the State.

27. **Implementation of Phase III.** Implementation of Phase III will occur over the course of the following 2 State fiscal years, with near or full geographic implementation of Medicaid Reform expected by June 2010. Phase III geographic expansion is targeted to culminate in Medicaid Reform plans being operational statewide. This will be accomplished in stages, again with mandatory and voluntary populations enrolled on a staggered basis.

    The fourth and final phase of Medicaid Reform implementation will occur once the geographic implementation is complete. This phase consists of expanding Reform to additional populations, specifically by mandating the enrollment of those population groups previously enrolled voluntarily. The area-by-area roll out of each population may be different for different population groups, depending upon the availability of fully developed networks. Enrollment may be limited to those areas that were fully implemented by the end of Phase II, thus enabling those with the most experience under Reform principles to be the initial sites for population expansion. The transition of these populations will also be on a staggered basis.

    In addition, by Phase III the State expects that the special care networks for children with chronic conditions will be fully developed beyond the Broward and Duval areas, either on a limited or statewide basis. Enrollment of these children will become mandatory in those areas with such networks.

VI. ELIGIBILITY

28. **Consistency with State Plan Eligibility Criteria.** The State assures CMS that the eligibility criteria under this demonstration shall be consistent with the criteria in the State Plan.

29. **Enrollment Process.** The State agrees to notify participants within 30-days of their entry into this demonstration.

30. **Eligibility for Medicaid Reform Demonstration.** During the initial phase, participation in Medicaid Reform will be mandatory for two eligibility groups currently covered by Florida Medicaid. The first group is the 1931 eligibles and related group, herein referred to as the TANF and TANF-related eligibility group. The second is the Aged and Disabled group.

Mandatory Participant Populations

Aged and Disabled Group (MEG 1):

- The aged and disabled, comprising persons receiving SSI cash assistance whose eligibility is determined by SSA (income limit approximately 75% of the FPL; asset limit for an individual is $2,000).
- Children eligible under SSI.
-

TANF and TANF-Related Group - 1931 Eligibles (MEG 2):

- Families whose income is below the TANF limit (23% of the FPL or $303 per month for a family of 3) with assets less than $2,000.
- Poverty-related children whose family income exceeds the TANF limit as follows:
  - Up to age one, family income up to 200% FPL.
  - Up to age 6, family income up to 133% of FPL.
  - Up to age 21, family income up to 100% FPL.

The above groups are mandatory Medicaid eligibles, with the exception of poverty level children up to age one with family income above 185 percent of FPL but below 200 percent of FPL.

31. **Initial Demonstration Voluntary Participation Populations.** During the initial phase, individuals as listed below, may voluntarily participate in the demonstration. The State anticipates that during subsequent phases, individuals identified as voluntary in the groups below, as well as additional eligibility groups not included during the initial phase-in, will be mandated to participate in demonstration. Specifically, children with chronic conditions participating in Children's Medical Services, foster care children and individuals with developmental disabilities will be required to participate in a reform program upon development and implementation of networks to meet their needs, as specified by the State Legislature.

The following individuals eligible under the TANF and SSI groups listed below will be excluded from mandatory participation during the initial phase:

a. Foster care children will be a mandatory population no later than the end of demonstration year 3.
b. Individuals with developmental disabilities will be a mandatory population no later than the end of demonstration year 3.

c. Children with special health care needs will be a mandatory population no later than the end of demonstration year 3.
d. Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD.
e. Individuals eligible under a hospice-related eligibility group (by year 5).
f. Pregnant women with incomes above the 1931 poverty level (by year 5).
g. Dual eligible individuals.

32. The State shall provide notification to CMS no later than 90 days prior to transitioning voluntary participants to a group mandated to participate in the Medicaid Reform demonstration. In accordance with item six in Section III "General Program Requirements," the State shall submit an amendment for identified groups prior to transitions.

33. **Enhanced Benefit Accounts Program Expansion Populations.** Individuals with incomes of less than 200 percent FPL, regardless of assets, who lose eligibility for Medicaid or subsidized employer sponsored insurance coverage, will continue to have limited eligibility under this demonstration. This expansion population retains Medicaid eligibility solely to access accrued funds in their individual Enhanced Benefit Account. The expansion eligibles will receive no other Medicaid benefits. The expansion population will be limited to individuals who have accrued funds in an individual enhanced benefit account.

34. **Voluntary and Expansion Eligibility Groups Expenditure.** The State is not obligated under this demonstration to extend eligibility to population groups listed above as voluntary populations, but may do so. The State must seek approval to modify program eligibility via the waiver amendment process as described in number six and seven of Section III "General Program Requirements." Regardless of any extension of eligibility, the State will be limited to Federal funding reflected in the budget neutrality requirements set forth in these STCs.

VII. ENROLLMENT

This section describes enrollment provisions and is subject to Section V, "Florida Medicaid Reform Demonstration Implementation."

35. **Staggered Enrollment.** Within each geographic demonstration area the State will stagger the transition for enrollment of mandatory participants into the Medicaid Reform demonstration.

36. **New Medicaid Reform Demonstration Enrollees.** At the time of eligibility determination, individuals who are mandated to participate will receive information about managed care plan choices in their area. They will be informed of their option to select an authorized managed care plan or opt out of Medicaid. Individuals will be given the opportunity to meet with a choice counselor (either State-employed or State-designated) to obtain additional information in making a choice. If they opt

out, they can use their Medicaid established premium to pay for employer-sponsored insurance, or private health insurance if they are self-employed. They will be required to select a plan or opt out within 30 days of eligibility determination. If the individual does not select a plan or opt out within the 30-day period, the State will auto-assign the individual into a Medicaid Reform Plan.

Once individuals have made their choice, they will be able to contact the State or the State's designated choice counselor to register their plan selection. The eligibility process will be considered complete once the individual has selected a managed care plan or has chosen to opt out of Medicaid. Until the individual makes a choice, or the individual is auto-assigned, the individual is only eligible for emergency services, nursing home care, and ICF/DD care. The State shall assure that appropriate mechanisms are in place to ensure that only claims for emergency services, nursing home level of care and ICF/DD are submitted to CMS for individuals who have not selected a plan within 30 days.

37. **Current Medicaid State Plan Enrollees.** Current Medicaid enrollees who are enrolled in a managed care plan or the MediPass program will be required to enroll in a reform plan at the time of their eligibility redetermination, or their open enrollment period, whichever is sooner.

During the transition period, current enrollees will be able to remain with their current managed care plan if it continues to provide the currently contracted package, either under the current contract or as a reform plan with the same benefit package. The State will create an open enrollment process for all enrollees in a plan if the plan no longer has a contract with the State or develops a plan that is different from the current managed care plan without maintaining the current benefit package. In this instance, since the plan is different, the State will allow all enrollees in the plan to remain enrolled in the plan or select a new reform plan.

Once an individual is redetermined eligible for Medicaid, enrollees will have 30 days to make a choice of a reform plan. If the individual does not make a selection, the state will auto-assign the individual to a reform plan to ensure that services will continue uninterrupted.

Medicaid recipients in the demonstration areas who are not currently enrolled in a capitated managed care plan upon implementation of Reform will have the opportunity to enroll in a managed care plan at the time of annual eligibility redetermination. An information and redetermination packet will be sent to the enrollee at least 45 days prior to the redetermination date. This packet will include information on the managed care plan choices in the area information on the opt-out option. The individual may choose to meet with a choice counselor to discuss the options. If the individual does not make a selection, the State will auto-assign the individual to a managed care plan to ensure that services will continue uninterrupted.

All current enrollees may voluntarily elect to enroll in a reform plan prior to their redetermination period. The State will treat the request to disenroll from the current plan as a good cause disenrollment request and allow the individual to enroll in the reform plan. In addition, all current Medicaid enrollees, regardless of the delivery system in which they are enrolled prior to Reform, may opt out of Medicaid at any time after the demonstration implementation date in their area.

38. **Auto-Enrollment Criteria.** Each enrollee will be given 30 days to select a managed care plan after being determined eligible for Medicaid. Within the 30-day period, the State or State's designated choice counselor will provide information to the individuals to encourage an active selection. Enrollees who fail to choose within this timeframe will be auto-assigned to a managed care plan. At a minimum, the State will use the criteria listed below when assigning an enrollee to a managed care plan. When more than one managed care plan meets the assignment criteria, the State will make enrollee assignments consecutively by family unit. The criteria are:

    - A managed care plan has sufficient provider network capacity to meet the need of enrollees.
    - The managed care plan has previously enrolled the enrollee as a member, or one of the plan's primary care providers has previously provided health care to the enrollee.
    - The State has knowledge that the enrollee has previously expressed a preference for a particular managed care plan as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.
    - The managed care plan's primary care providers are geographically accessible to the recipient's residence.

    For an enrollee who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan, the State will determine whether the SSI recipient has an ongoing relationship with a provider or managed care plan; and if so, the State will assign the SSI recipient to that managed care plan whenever feasible. Those SSI recipients who do not have such a provider relationship will be assigned to a managed care plan using the assignment criteria previously outlined.

39. **Lock-In/Disenrollment in a Medicaid Reform Plan.** Once a mandatory enrollee has selected a Medicaid Reform Plan the enrollee shall be enrolled in the plan for a total of 12 months, which includes a 90-day disenrollment period. Once an individual is enrolled into a Medicaid Reform Plan the individual will have 90 days to voluntarily disenroll from that plan and select another plan. If an individual chooses to remain in the plan past 90 days the individual will remain in the selected plan for an additional nine months for a total enrollment period of 12 months, and no further changes may be made until the next open enrollment period except for cause. Cause shall include: enrollee moves out of the plan's service area; enrollee needs related services to be performed at the same time, but not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to

unnecessary risk. Other reasons for cause may include but are not limited to: quality of care, lack of access to necessary services, an unreasonable delay or denial of services, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. Enrollees may transfer between primary care providers within the same managed care plan. Voluntary enrollees may disenroll from the reform plan at any time.

The choice counselor will record the plan change/disenrollment reason for all recipients who request such a change. The State or the State's designee will be responsible for processing all enrollments and disenrollments.

40. **Opt-Out: Employer Sponsored Insurance.** Enrollees will be able to opt out of Medicaid at any time to enroll in an employer-sponsored insurance program (ESI). The decision to opt out of Medicaid and elect ESI is completely voluntary. The State will provide an enrollee who chooses to opt out of Medicaid and enroll in an ESI plan with a 90-day change period.

The 90-day change period may be limited by the employer in order to comport with the employer's open enrollment period. After 90 days, no further changes may be made until the next employer-sponsored open enrollment period which includes qualifying events, or unless the enrollee no longer has access to employer-sponsored coverage.

41. **Re-enrollment.** In instances of a temporary loss of Medicaid eligibility, which the State is defining as 6 months or less, the State will re-enroll reform enrollees in the same health plan they were enrolled in prior to the temporary loss of eligibility.

42. **Enrollment Cap Parameters.** The State of Florida shall not place enrollment caps on current State Plan eligible individuals. The State of Florida may impose an enrollment cap on non-State Plan demonstration eligibles that receive services funded through the Low Income Pool as described in Section XV, "Low Income Pool."

VIII. CHOICE COUNSELING

43. **Choice Counseling Defined.** The State shall contract with an independent choice counselor to provide full and complete information about managed care plans choices and the ability to opt out of Medicaid. As directed by the State Legislature, the State will develop a choice counseling system that promotes and improves health literacy and provides information to reduce minority health disparities through outreach activities.

44. **Developing Choice-Counseling Materials.** Through the choice counselor the State will develop an extensive enrollee education and rating system so individuals will fully understand their choices and be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan, and the data will be made available publicly.

45. **Choice Counseling Information to be Provided.** Specifically, the choice counselor will provide information on either selecting a reform plan or opting out of Medicaid. The choice counselor will provide information to individuals interested in opting out, explain the concept and reenrollment provisions and provide contact information regarding the administrator. The choice counselor will assist the individual in making an informed choice about opt-out by highlighting information the individual will need to consider in order to make a fully informed choice. As it does now, the State or the State's designated choice counselor will provide information about each plan's coverage in accordance with Federal requirements. Additional information will include, but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. In addition, the State will supplement coverage information by providing performance information on each plan. The supplement information may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance data.

46. **Choice Counseling for Opt-Out Provision.** Individuals interested in opt-out will be encouraged to contact their employer and the State's contract administrator for the opt-out program for additional information. The choice counselor will collect information on whether the individual has access to health insurance. At a minimum, the choice counselor will encourage the individual to determine available health insurance; when the individual can enroll; review of cost-sharing requirements of the plan; information about preexisting conditions clauses; and whether individual or family coverage is available. The choice counselor will then refer the individual to the State's administrator, which will assist the individual in the opt-out process. The administrator will contact the employer and verify available health insurance. To ensure enrollees understand this option, the administrator may periodically contact individuals regarding the opt-out option.

47. **Delivery of Choice Counseling Materials.** Choice counseling materials will be provided in a variety of ways including print, telephone, and face-to-face. All written materials shall be at the fourth-grade reading level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY.

48. **Contacting the Choice Counselor.** Individuals will be able to contact the State or the State's designated choice counselor to obtain additional information. The State or the choice counselor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees.

IX. BENEFIT PACKAGES & MEDICAID REFORM PLANS

49. **Customized Benefit Packages for Medicaid Reform.** Medicaid Reform Plans will have the flexibility to provide customized benefit packages for Medicaid Reform enrollees. The customized benefit packages must cover all mandatory services specified in the State Plan including medically necessary services for pregnant women and EPSDT services for children under age 21. In addition, the plans will cover needed optional services as indicated by historical data. However, the amount, duration and scope of all covered services, mandatory and optional, may vary to reflect the needs of the population. The plans authorized by the State shall not have service limits more restrictive than authorized in the State Plan for children under the age of 21, pregnant women, and emergency services. The State may also capitate all State Plan services in a demonstration area.

50. **Overall Standards for Customized Benefit Packages.** All benefit packages must be prior-approved by the State and must be at least actuarially equivalent to the services provided to the target population under the current State Plan benefit package. In addition the plan's customized benefit package must meet a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population.

51. **Risk Adjusted Premium Development for Customized Benefit Packages.** The State will separate the Medicaid premium into two components – comprehensive care and catastrophic care. The distinction between comprehensive and catastrophic coverage is with respect to the development of the premium and related only to the risk level the Medicaid Reform Plan will retain. The aggregate premium will be based on historical utilization of currently covered mandatory and optional services. Based on this aggregate premium, the State will develop a premium for each component.

52. **Comprehensive Care Premium Development.** The comprehensive care component includes the Medicaid services that the majority of Medicaid enrollees will need and is expected to represent approximately 90 percent of historical medical expenditures. Initially, comprehensive care premiums may be based on eligibility groups, age, and gender for a specified geographic area and then risk adjusted for health status. All health plans will be at risk for the comprehensive care premium and will provide all services outlined in their customized benefit packages approved by the State.

53. **Catastrophic Care Premium Development.** The catastrophic care component is designed to meet the needs of the limited number of Medicaid enrollees who have unusually high costs in any particular year. For each target population served, the State will establish criteria to allow plans to choose whether or not to assume the catastrophic risk.

54. **State Benefit Plan Evaluation Model.** The State will develop a Benefit Plan Evaluation Prototype to determine if a plan that is applying for a Medicaid Reform

Plan contract meets State requirements. The evaluation tool will measure for actuarial equivalency and sufficiency. Specifically, it will 1) compare the value of the level of benefits in the proposed package to the value of the current State Plan package for the average member of the population and 2) ensure that the overall level of benefits is appropriate. The State will evaluate service utilization on an annual basis and use this information to update the prototype to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

55. **State Benefit Plan Evaluation Model: Actuarial Equivalency.** Actuarial equivalence is evaluated at the target population level and is measured based on that population's historical utilization of services for current Medicaid State Plan services. This process will ensure that the expected claim cost levels of all reform plans are equal (using a common benchmark reimbursement structure) to the level of the historic fee-for-service plan for the target population and its historic levels of utilization. The State will use this as the first threshold to evaluate the customized benefit package submitted by a plan to ensure that the package earns the premium established by the State. In assessing actuarial equivalency, the evaluation model will consider the following components of the benefit package: services covered; cost sharing; additional benefits offered, if any; and any global limits. Additional services offered by the plan will be considered a component of the plan's customized benefits and not a component of the Enhanced Benefit plan.

56. **State Benefit Plan Evaluation Model: Sufficiency**. In addition to meeting the actuarial equivalence test, each health plan's proposed customized benefit package must meet State-established standards of benefit sufficiency. These standards will be based on the target population's historic use of Medicaid State Plan services. The State will identify specific services (e.g., inpatient hospital, outpatient physician care, behavioral health, and prescription drugs) and will evaluate each proposed benefit plan against the sufficiency standard to ensure that the proposed benefits are adequate to cover the needs of the vast majority of enrollees. The sufficiency standard for a service may be based on the proportion of the historical utilization for the target population that is expected to exceed the plan's proposed benefit level.

57. **Comprehensive Component Limits for Reform Plans**. The comprehensive component will cover 100 percent of the cost of an enrollee's care, less any required enrollee cost sharing, until that care reaches an established threshold. At that time the expenses for care, less any required plan co-insurance, become subject to the catastrophic component. Through a plan cost sharing mechanism, a small portion of the expenses over the threshold will be retained within the comprehensive component of the premium to ensure that plans not bearing catastrophic risk have financial motivation to continue to manage care efficiently. The actual proportion of the total premium dedicated to the comprehensive component will depend upon the threshold level and the post-threshold plan co-insurance established for the catastrophic component. The proportion may vary among target populations.

58. **Catastrophic Component**. The catastrophic premium component covers the bulk of

an individual's medical expenses, less any required plan cost sharing, after those expenses exceed a pre-established catastrophic threshold. Health plans cannot choose to accept catastrophic risk on an individual recipient basis, nor can they change the decision for a target population during a plan year. If a plan chooses not to cover the catastrophic component, the State will assume the financial risk for catastrophic services furnished by the plan.

The State expects that less than 10 percent of the aggregate premium will need to be allocated to the catastrophic care component. However, the actual portion of premium dedicated to the catastrophic component will depend on the established threshold level and plan cost sharing.

59. **Mechanics of an Individual Catastrophic Threshold.** An individual's medical expenses become subject to catastrophic component funding when one of two defined thresholds is reached: 1) dollar threshold or 2) inpatient day threshold. The established thresholds may vary across populations (e.g., TANF vs. aged and disabled) and across health plans as part of negotiations to bring in new managed care entities.

60. **Dollar Threshold for Triggering Catastrophic Threshold.** All health care expenditures for each individual will be accumulated throughout the plan year and compared to a pre-established dollar threshold. The dollar threshold is derived from the historical utilization analysis used to develop the comprehensive and catastrophic premiums. The methodology for deriving the dollar threshold will be based on high-cost claims analysis, the desired amount of the high-cost claims to be retained in the comprehensive premium component (i.e., plan cost sharing), and the desired percentage of medical expenses covered by the catastrophic component.

If an individual's expenses exceed that threshold, the remainder of the expenses, excluding any required plan cost sharing, for that individual are provided through the catastrophic premium component, up to a maximum per-year benefit limit.

61. **Inpatient Day for Triggering Catastrophic Threshold.** The current Medicaid State Plan limits Medicaid coverage of inpatient hospital days to 45 days per state fiscal year for individuals over age 21. It is possible that a customized benefit plan may include fewer covered inpatient hospital days, yet still meet the sufficiency test for certain target populations. However, the State will provide up to 45 days of inpatient coverage regardless of the nominal limit established by the health plan and those excess days will be funded through the catastrophic premium component. The State will establish a separate inpatient day threshold that will trigger payment through the catastrophic premium component for inpatient care that occurs after covered days are used and prior to the dollar threshold being met.

62. **Overall Annual Aggregate Maximum.** The State will also establish an overall annual maximum benefit level in conjunction with the development of the premium components. The maximum benefit limit will be applied to all reform recipients with

the exception of children under age 21 and pregnant women. The annual aggregate maximum limit provides a safeguard to enrollees, as the annual limit will renew each year to cover additional services.

63. **Medicaid Reform Plans Responsibilities.** All health plans will be responsible for providing and coordinating all recipient benefits, regardless of whether those benefits are being funded through the comprehensive or catastrophic premium component and regardless of whether the plan has chosen to bear financial risk for catastrophic care. For those plans that do not accept financial risk, the State becomes the re-insurer, and the health care plan remits claims to the State for services rendered under this component. The move from comprehensive to catastrophic is seamless for the enrollee, and the enrollee does not know which health plans are at risk for the catastrophic component.

64. **Safeguards to Minimize Cost-Shifting & Maximize Enrollee Care**. To minimize financial cost shifting and to maximize enrollee care the State will require the following:

State notification - Health plans must notify the State when they have paid claims reaching a specific amount, such as 50 percent of the catastrophic dollar threshold. This puts the State on notice that an individual may reach the dollar or inpatient day threshold during the fiscal year. This will also provide the State the opportunity to intervene, through utilization review or peer review, if appropriate, in the management of the delivery of care. The State may implement penalties if a health plan fails to properly notify the state.

Fee-for-service pricing - Each health care plan will have the flexibility to reimburse its providers by the method of its choosing, and in the amounts of its choosing. This creates an opportunity for a health plan to pay providers considerably more than market rates, yet still be protected from further financial loss because the catastrophic care component would step in at a defined amount.

To prevent this opportunity for cost shifting, each health plan will be required to maintain a shadow claims process whereby all claims are re-priced at the Medicaid fee schedule. An enrollee will reach the dollar threshold only when claims priced at the Medicaid fee schedule reach the threshold, regardless of the actual rates paid to network providers. Reinsurance to the plan will be based only on the Medicaid fee schedule.

Health care plan co-insurance - For those health plans that choose not to accept risk for the catastrophic component, once an individual becomes eligible for the catastrophic component, the State will act as the re-insurer and will pay the catastrophic claims submitted by the health plan. The health plan will continue to manage and coordinate care for the Medicaid enrollee. To ensure that there is adequate incentive for the plans to appropriately manage care once an individual gets close to the dollar or inpatient day threshold, the health care plan will be

required to pay a co-insurance amount for each catastrophic claim and their on-going cost. Once the threshold is crossed, the State will pay the bulk of (e.g. 90 to 95 percent) the catastrophic claim based on the Medicaid fee schedule, and the health plan will pay the co-insurance (e.g. 5 to 10 percent) of the catastrophic claim along with any amount greater than the Medicaid fee schedule and its own provider reimbursement arrangement. The value of the plan coinsurance will be incorporated into the comprehensive premium component. Plans will have financial incentive to manage the enrollee, as the plans will keep the value of the coinsurance for individuals who do not enter into the catastrophic component.

65. **Marketing**. Approved managed care plans will be allowed to market to individuals within the parameters defined by law to prevent inappropriate or unfair marketing. With prior approval from the State, direct marketing will be permitted and may include direct mailings, health fairs, and other activities. The State will assure that all plans comply with section 1932(d)(2) of the Act and 42 CFR 438.104, Marketing Activities. In addition to the Federal requirements, Florida law prohibits plans from offering gifts or other incentives to potential enrollees and managed care plans from providing inducements to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other managed care plans.

X. EMPLOYER SPONSORED INSURANCE

66. **Employer Sponsored Insurance Populations.** Mandatory and voluntary Medicaid Reform enrollees may voluntarily opt-out of Medicaid Reform plans into an employer sponsored insurance (ESI) plan or a private insurance plan when available.

67. **90-Day Opt-Out Provision.** An enrollee who chooses to opt-out of the Medicaid reform plan shall have 90-days to opt back into a Medicaid Reform Plan. The 90-day change period may be limited by the employer in order to comport with the employer's open enrollment period. After 90 days, no further changes may be made until the next employer-sponsored open enrollment period which includes qualifying events, or unless the enrollee no longer has access to the employer-sponsored coverage.

68. **Payment of Premium Share.** Individuals choosing to participate in the ESI option will register with the State's contractor and will provide all pertinent employer information, including the amount of the employee contribution for the ESI plan. The State's contracted administrator will be responsible for contacting the employer to verify coverage information and establish payment of the employee's share of the premium.

69. **Portion of the Premium Share to be Paid.** The State shall provide the employee share but no more than the Medicaid authorized premium. If the employee contribution for the ESI plan exceeds the Medicaid authorized premium, then the enrollee will be responsible for paying the additional amount. If the employee contribution is less than the Medicaid authorized premium, the enrollee may use the remainder of the premium to purchase family coverage or purchase supplemental health insurance coverage offered by the employer. The State may limit payment for

supplemental policies to ensure efficient use of premium dollars. The availability of supplemental policies may provide access to services not currently covered by Medicaid such as adult dental coverage. Payment will be made directly to the employer of record whenever possible. In the case of an enrollee that is self-insured and has private coverage, payment will be made directly to the insurer of record.

70. **Benefits and Cost Sharing Employer Sponsored Insurance.** The benefit package under the ESI plan must meet minimum state licensure standards, but may be more restrictive than Medicaid coverage. The State will not provide wrap-around benefits with the exception of any funds accrued in the individual Enhanced Benefits Account. Enrollees electing to opt-out will be responsible for paying the cost sharing requirements of the ESI plan, including deductibles, co-insurance and co-payments. Medicaid does not contract directly with these entities and does not have the ability to limit cost sharing. ESI cost sharing requirements may be higher than the cost sharing requirements under Medicaid. Since the enrollee has voluntarily chosen to participate in the ESI option, the State will not provide cost sharing or wrap around services.

71. **Statewide Subscriber Assistance Panel.** Individuals electing to opt-out into an ESI plan that is a licensed HMO, Exclusive Provider Organization (EPO) or a prepaid health plan authorized under Section. 409.912, Florida Statute will be able to appeal grievances not resolved through the required internal grievance process to the Statewide Subscriber Assistance Panel. The State-level panel will review grievances within the following timeframes:
    - 45 day – General grievances;
    - 120 days – Grievances that the agency determines poses an immediate and serious threat to a subscriber's health.
    - 24 hours – Grievances that the agency determines relate to imminent and emergent jeopardy to the life of the subscriber.

72. **Opt-Out Guidelines.** The State will provide CMS with a document that details the administration of the opt-out program at least 30-days prior to implementation. The document will include the safeguards used to verify employer-sponsored coverage, the employee's share of premiums and any respective cost-savings.

XI. ENHANCED BENEFIT ACCOUNTS PROGRAM

73. **Enhanced Benefit Accounts Program Defined.** Enhanced Benefits Accounts (EBA) will be established to provide incentives to Medicaid reform enrollees for participating in State defined activities that promote healthy behaviors. An individual who participates in a State defined activity that promotes healthy behavior shall have funds deposited into the individual EBA. These funds shall be used for health care related expenditures as defined in Section 1905 of the Act. The State will directly manage the development of policies and procedures that govern the Enhanced benefit plan by establishing the Enhanced Benefit Panel.

74. **Administration Overview.** The State will establish a list of activities that will generate contributions to the account. A menu of benefits or programs will be

provided as will the individual value of each item on the menu. The amount available to individuals from their enhanced benefit account will depend on the activities in which they participate up to a maximum amount. Once an enrollee completes an approved activity, the enrollee will be considered an active participant. The State will deposit earned funds into an account for use by the enrollee. Additional funds may be earned as the enrollee participates in additional activities. In no instance will the individual receive cash.

75. **Participants Earning Enhanced Benefits Accounts Defined.** All enrollees in a Medicaid reform plan, including mandatory and voluntary enrollees, will be eligible to participate in activities to earn Enhanced Benefits for the duration of their enrollment. The State shall exclude Medicaid individuals who choose to opt-out of Medicaid reform plans. The exception to this provision is at the time of EBA Program phase out as discussed in Section III, "General Program Requirements,"

76. **Participant Access to Funds.** The State will provide access to an individuals earned funds in an Enhanced Benefit Account as follows:

- Individuals who are enrolled in a reform plan and who have participated in a State defined activity that promotes healthy behavior and thus have a positive balance.

- Individuals who no longer are enrolled in a reform plan (either due to loss of eligibility, change of eligibility to an eligibility group not authorized to participate, or opting out of Medicaid), but who have a positive balance in their account.

- Regardless of the reason for the loss of eligibility to participate in the demonstration, an individual may retain access to any earned funds for a maximum of 3 years, so long as, the individual's income is below 200 percent of the FPL.

- If an individual subsequently regains Medicaid eligibility, the enrollee will be eligible to participate in the EBA Program and earn additional funds.

77. **Federal Financial Participation.** The State shall claim Federal financial participation (FFP) at the time funds are deposited into an account. For purposes of FFP, the deposit of funds into an account will be considered an eligible expenditure at the time the funds are deposited.

78. **Deposit of Earned Funds for the Enhanced Benefit Accounts Program.** The State agrees that all funds earned for the EBA program by individuals eligible under the demonstration shall be deposited into an escrow type account. These funds shall not be commingled with other State funds or accessible by the State for any other purpose other than the EBA program. Applicable amounts will be withdrawn from this account as individuals make a transaction for authorized expenditures under the EBA program.

79. **Dormant Account Reconciliation.** The State will establish a process to review

dormant accounts at the end of the 3-year period. The State will recoup any unspent funds and then return the Federal portion to CMS in a timely manner.

80. **Enhanced Benefits Accounts Milestones.** The State shall provide CMS a copy of any procurement document issued to obtain a contractor to administer the Enhanced Benefit Program. In addition, the State will provide the CMS Regional Office a copy of the contract for approval to administer the Enhanced Benefit Program. At a minimum, the contract will specify the scope of work, duration of the contract, and the amount of contract.

81. **Effective and Efficient Administration.** The State will submit documentation on an annual basis related to EBA eligibility activities, respective earnings for each activity, eligible health related expenditures, access to account information, and accounting requirements. The State will include this information in the Annual Report and Quarterly Reports as discussed in Section III, "General Reporting Requirements." The State will assure effective and efficient administration of the program.

XII. COST SHARING

82. **Premiums and Co-Payments.** The State must exempt enrollees from cost sharing for those services and populations identified in 42 CFR 447.53-54. The state must pre-approve all cost sharing allowed by plans. In no instance shall cost sharing exceed the nominal levels identified in 42 CFR 447.53-54 as specified in the State Plan, as of June 2005 and the following chart.

Services	Co-payment / Co-insurance
Birthing Center	$2 per day per provider
Chiropractic	$1 per day per provider
Community Mental Health	$2 per day per provider
Dental – Adult	5% co-insurance per procedure
FQHC	$3 per day per provider
Home Health Agency	$2 per day per provider
Hospital Inpatient	$3 per admission
Hospital Outpatient	$3 per visit
Independent Laboratory	$1 per day per provider
Hospital Emergency Room	5% co-insurance up to the first $300 for each non-emergent visit
Nurse Practitioner	$2 per day per provider
Optometrist	$2 per day per provider
Pharmacy	2.5% co-insurance up to the first $300 for a maximum of $7.50 a month
Physician and Physician Assistant	$2 per day per provider
Podiatrist	$2 per day per provider
Portable X-Ray	$1 per day per provider
Rural Health Clinic	$3 per day per provider
Transportation	$1 per trip

Any changes to cost sharing must be submitted as an amendment to the demonstration or the State Plan for CMS approval.

83. **Employer Sponsored Insurance Cost Sharing.** For individuals who voluntarily choose to opt-out into ESI plan, cost sharing will be consistent with the requirements under the enrollee's specific ESI program. In accordance with State and Federal insurance laws cost sharing imposed by ESI plans may exceed Medicaid limits. Since the enrollee has voluntarily chosen to participate in the ESI option, the State will not provide additional funds for cost sharing or wrap around services.

XIII. DELIVERY SYSTEMS

84. **Health Plans.** The MCOs must be authorized by State Statute and must adhere to 42 CFR 438. Capitation rates, including both components of the comprehensive and catastrophic components, shall be developed and certified as actuarially sound in accordance with 42 CFR 438. The certification shall identify historical utilization of state plan services used in the rate development process. Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS Regional Office approval prior to implementation.

85. **Freedom of Choice.** An enrollee's Freedom of choice of providers shall be limited to and through whom individuals may seek services, including the enhanced benefits accounts program for populations enrolled in the Florida Medicaid Reform demonstration.

86. **Contracting with Federally Qualified Health Centers (FQHCs).** Prior to the start date of the demonstration, the State will review health plan and physician capacity to ensure that it is adequate to serve the expected enrollment as part of the ongoing monitoring of the demonstration. The State will require plans, to make a good faith effort to include Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and County Health Departments (CHDs) in their network. If a plan can demonstrate to the State and CMS that both adequate capacity and an appropriate range of services for vulnerable population exists to serve the expected enrollment in all service areas without contracting with FQHCs, RHCs, or CHDs, the plan can be relieved of this requirement. The State shall evaluate the number of FQHCs/RHCs and CHDs that contract with plans and make this information available to CMS upon request.

87. **Evaluation of Plan Benefits.** The State will review and update the Evaluation Benefit Plan Prototype for assessing a plan's benefit structure to ensure actuarial equivalence and that services are sufficient to meet the needs of enrollees in the Medicaid Reform area. At a minimum, the State must conduct the review and update on an annual basis. The State will provide CMS with 60-days advance notice and a copy of any proposed changes to the Evaluation Benefit tool.

XIV. EVALUATION

88. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval within 120 days from the award of the Demonstration a draft evaluation design. At a minimum, the draft design shall include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population and capitated revenue expenditures for the Demonstration. The draft design shall discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State shall conduct the evaluation, or select an outside contractor for the evaluation.

89. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS comments. The State shall implement the evaluation design, and as stated in section III, "General Reporting Requirements," submit its progress in the quarterly reports. The State shall submit to CMS a draft of the evaluation report 120 days after the expiration of the current demonstration period (March 31, 2011). CMS shall provide comments within 60 days of receipt of the report. The State shall submit the final evaluation report for this demonstration period by August 31, 2011.

90. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration.

XV. LOW INCOME POOL

91. **Low Income Pool Definition.** A Low Income Pool (LIP) will be established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low-income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period.

92. **Availability of Low Income Pool Funds.** Funds in the LIP will become available upon implementation of Florida Medicaid Reform, which shall be no later than July 1, 2006, provided the pre-implementation milestones are met as discussed below in Section XVI "Low Income Pool Milestones."

93. **Reimbursement and Funding Methodology Document.** In order to define LIP permissible expenditures the State shall submit for CMS approval a Reimbursement and Funding Methodology document for the LIP expenditures and LIP parameters defining State authorized expenditures from the LIP and entities eligible to receive reimbursement. This is further defined in Section XVI, "Low Income Pool Milestones." Any subsequent changes to the CMS approved document will need to be submitted as an amendment to the demonstration as defined in item six in Section III, "General Program Requirements."

94. **Low Income Pool Permissible Expenditures.** Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS

95. **Low Income Pool Expenditures - Non-Qualified Aliens.** LIP funds cannot be used for costs associated with the provisions of health care to non-qualified aliens.

96. **Low Income Pool Permissible Expenditures 10 percent Sub Cap.** Up to 10 percent of the capped annual allotment of the LIP funds may be used for hospital expenditures other than payments to providers for the provision of health care services to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers. The reimbursement methodologies for these expenditures and the non-Federal share of funding for such expenditures will be defined in the Reimbursement and Funding Methodology Document as discussed in item 91 of this section and Section XVI, "Low Income Pool Milestones."

97. **Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid at cost and will be further defined in the Reimbursement and Funding Methodology Document utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost and this requirement is further clarified with the submission of a corresponding State Plan Amendment, as outlined in the pre-implementation milestones in Section XVI, "Low Income Pool Milestones."

98. **Low Income Pool Permissible Non-Hospital Based Expenditures.** To ensure services are paid at cost, CMS and the State will agree upon cost-reporting strategies

and define them in the Reimbursement and Funding Methodology document for expenditures for non-hospital based services.

99. **Permissible Sources of Funding Criteria.** At least, 120 days prior to the demonstration implementation the State must submit for CMS approval the source of non-Federal share used to access the LIP, as outlined in the pre-implementation milestones. The State shall not have access to these funds until the source of non-Federal share has been approved by CMS. CMS assures the State that it will review the sources of non-Federal share in a timely manner. Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes) shall be impermissible.

XVI. LOW INCOME POOL MILESTONES

100. **Pre-Implementation Milestones.** The availability of funds for the LIP in the amount of $1 billion is contingent upon the following items prior to implementation:

    a. The State's submission and CMS approval of a Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement.
    b. Florida's submission and CMS approval of a State Plan Amendment (SPA) that will terminate the current inpatient supplemental payment upper payment limit (UPL) program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. Nothing herein precludes the State from submitting a State Plan Amendment reinstituting inpatient hospital supplemental payments upon termination of this demonstration. The State agrees not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration.
    c. The State shall submit a State Plan Amendment for CMS approval limiting the inpatient hospital payment for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96.
    d. The State shall submit for CMS approval of all sources of non-Federal share funding to be used to access the LIP. The sources of the non-Federal share must be compliant with all Federal statutes and regulations.
    e. The State's ability to access the restricted portion of funds at the time of implementation and for the duration of the demonstration shall be contingent upon the State's capacity to meet the following milestones outlined in this Section.

101. **Demonstration Year 1 Milestones.** The State agrees that within 6 months of implementation of the demonstration it will submit a final document including CMS comments on the Reimbursement and Funding Methodology document (referenced in item 91). The final document shall detail the payment mechanism for expenditures made from the LIP to pay for medical expenditures for the uninsured and qualified

aliens including expenditures for 10 percent of the LIP used for other purposes as defined in paragraph 94. This document shall also include a reporting methodology for the number of individuals and types of services provided through the LIP. This methodology shall include a projection of these amounts for each current year of operation, and final reporting of historical demonstration periods. Providers with access to the LIP and services funded from the LIP shall be known as the provider access system. Any subsequent changes to the CMS approved document will need to be submitted as an amendment to the demonstration as defined in item six in Section III, "General Program Requirements."

102. **Demonstration Year 2 Milestones.** At the beginning of demonstration year 2, $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year one for a total of $1 billion.

The State will conduct a study to evaluate the cost-effectiveness of various provider access systems. The results of this study shall be disseminated to the provider access systems for the continuous improvement in the structure, scope and access to such systems.

During demonstration year 2, using the results of the study as a guideline, the State and CMS will define the scale of the provider access systems and the indicators used to measure the impact of such systems on the uninsured, which will be funded through the low-income pool for demonstration years 3 through 5.

By the end of demonstration year 2, the State will develop a plan for the continuous improvement of provider access systems and evaluation of the impact of these systems on the uninsured to be implemented in demonstration year 3.

By the end of demonstration year 2, the State will develop a plan for the statewide implementation of the demonstration by the end of waiver year 5.

103. **Demonstration Year 3 Funding.** At the beginning of demonstration year 3, $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year 2 for a total of $1 billion

Demonstration Year 3 Milestone. The State shall implement the indicators established under the plan for continuous improvement of provider access systems for the uninsured as indicated in demonstration year 2.

104. **Demonstration Year 4.** At the beginning of demonstration year four $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year 3 for a total of $1 billion.

Demonstration Year 4 Milestone. The State shall identify the qualitative impact on the implemented indicators in demonstration year 3 on uninsured individuals. This analysis may require the State to adjust the indicators as necessary.

105. **Demonstration Year 5.** At the beginning of demonstration year 5, $700 million will be available. An additional $300 million will be available at the time the demonstration is operating on a statewide basis for a total of $1 billion.

XVII. OTHER DEMONSTRATION MILESTONES

106. **Other Demonstration Milestones.** The State agrees it must adhere to all of the timeframes and deliverables specified in the sections outlined below in order to be considered compliant with Section XVI, "Low Income Milestones:"

1. Section IV. General Reporting Requirements
    a. Quarterly Reports
    b. Annual Reports
2. Section V. Florida Medicaid Reform Demonstration Implementation
3. Section VIII. Choice Counseling
    a. Developing Choice Counseling Materials
4. Section X. Employer Sponsored Insurance
    a. Opt-Out Guidelines
5. Section XI. Enhanced Benefit Accounts Program
    a. Enhanced Benefit Accounts Milestones
6. Section XIV. Evaluation
    a. Submission of Draft Evaluation Design
    b. Final Evaluation Design and Implementation
7. Section XVI. Low Income Pool Milestones

XVIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

107. **Quarterly Expenditure Reports.** The State shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under Section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide Federal Financial Participation (FFP) for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIX (Monitoring Budget Neutrality for the Demonstration).

108. **Reporting Expenditures Subject to the Budget Neutrality Cap.** The following describes the reporting of expenditures subject to the budget neutrality cap:

a) In order to track expenditures under this Demonstration, Florida shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which service was provided or for which capitation payments were made – incurred/accrual basis). Corrections for any incorrectly reported demonstration expenditures for previous demonstration years must be input within 3 months of the beginning of the Demonstration. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 108.c.

b) For each demonstration year at least three separate Form CMS-64.9 WAIVER and/or 64.9P WAIVER reports must be submitted reporting expenditures subject to the budget neutrality cap – more than three forms will be needed when there is more than one date of service year. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported on waiver forms. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 108.c.). The Florida Medicaid Reform eligibility groups (MEGs), for reporting purposes, include the following names and definitions:

MEG 1: SSI
MEG 2: TANF
MEG 3: Low Income Pool

c) For purposes of this section, the term "expenditures subject to the budget neutrality cap" shall include all Medicaid expenditures on behalf of the individuals who are enrolled in this Demonstration (as described in item 106.b.of this section) and who are receiving the services subject to the budget neutrality cap, with the exception of the excluded services identified at the end of this paragraph. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and shall be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver. The excluded services are the following:

Excluded Services
AIDS Waiver (Waiver Services)
DD Waiver (Waiver Services)
Home Safe Net (Behavioral Services)
BHOS (Services Only)
ICF/DD Institutional Services
Family & Supported Living (W.S.)
Katie Beckett Model Waiver Services
Brain & Spinal Cord Waiver Services
School Based Admin Claiming
Healthy Start Waiver Services

d) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS on Form CMS-64. In order to assure that the Demonstration is properly credited with premium collections, all premium collections from demonstration participants must be separated from other collections in the State's Medicaid program and reported in the narrative portion of the CMS-64 report as well as reported on line 9.D of the CMS-64 Summary Sheet.

e) Administrative costs shall not be included in the budget neutrality limit. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

109. **Reporting Member Months.** The following describes the reporting of member months subject to the budget neutrality cap:

a) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible

for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

b) The term "Demonstration eligibles" excludes unqualified aliens and generally refers to the following categories of enrollees, pursuant to the waiver specifications and expenditures included in budget neutrality, with the exceptions noted in paragraph 106.d:

MEG 1: SSI
MEG 2: TANF
MEG 3: Low Income Pool

c) For the purpose of monitoring the budget neutrality expenditure cap described in Section XIX, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined above. This information must be provided to CMS in conjunction with the quarterly progress report referred to in number 22 of Section IV. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.)

d) The excluded eligibles are the following:

Excluded Eligibles
Refugee Eligibles
Dual Eligibles
Medically Needy
PW above TANF Eligible (>27% FPL, SOBRA)
ICF/DD Eligibles
Unborn Children
State Mental Facilities (Over Age 65)
Family Planning Waiver Eligibles
Women w/ breast or cervical cancer
MediKids

110. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the Demonstration. Florida must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

111. **Non-Federal Share of Funding Conditions and Availability of Federal financial payments (FFP).** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Section XIX:

1. Administrative costs associated with the direct administration of Florida Medicaid Reform at the appropriate FFP rate authorized under Medicaid.

2. Net expenditures and prior period adjustments of the Medicaid and Florida Medicaid Reform programs, which are paid in accordance with the approved State plan. CMS will provide FFP for medical assistance payments with dates of service and during the operation of the 1115 waiver.

3. The employee subsidy portion of the ESI, as subsidized by the State of Florida, provided that the employer or self-employed person contributes. In no instance shall the subsidy exceed the premium, which would be paid to a Medicaid capitated plan in the absence of the individual not opting out of Medicaid. The program is limited to enrollees eligible for Medicaid, as authorized under the current state plan.

4. Health insurance (individual, two-person, or family) purchased by a self-employed person on his/her own behalf, will be treated as employer-sponsored insurance, and will be eligible for employer subsidies and employee subsidies which, are for FFP purposes, subject to the same limits

5. Net Expenditures associated with the Low Income Pool, as described in Section XV.

6. Net Expenditures associated with the Enhanced Benefits Accounts Program.

112. **State Certification of Funding.** The State shall certify State/local monies used as matching funds for the Demonstration and shall further certify that such funds shall

not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

113. **MSIS Data Submission.** The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The State shall ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

XI. MONITORING BUDGET NEUTRALITY

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The Special Terms and Conditions specify the two independent financial caps on the amount of Federal Title XIX funding that the State may receive on expenditures subject to the budget neutrality cap as defined in 106.c. of Section X of this document. Federal financial payments for the Medicaid Reform aspects of the demonstration are limited by a per member per month method cap and the payments for the Low Income Pool aspects are limited by an aggregate cap.

114. **Budget Neutrality Limit for the Low Income Pool.** Florida will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The Low Income Pool amount will be capped at $1 billion total computable for each year of the demonstration for a total of $5 billion. In each year, use of a specific amount of the Pool is restricted by the provisions of Paragraphs 100 through 105 of the terms and conditions. Unexpended funds from the restricted amount may not be used for purposes other than these provisions and may not be carried over to other years. For the balance of the Pool amount each year, any unexpended portion may be expended for Pool purposes in subsequent demonstration years subject to clause 94. The Federal share of the annual $1 billion total computable is the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures for the Low Income Pool MEG, subject to the previous conditions on what portions may be carried over from year to year. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

115. **Budget Neutrality Limit under the Per Capita Cost Per Month Method.** The limit is determined by using a per capita cost per month (PCCM) method, and budget targets are set on a yearly basis with a cumulative budget limit for the length

of the entire Demonstration. In this way, Florida will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing Florida at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

116. **Calculating the Per Capita Cost Per Month.** For the purpose of calculating the overall PCCM expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures for the SSI and TANF MEGs. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

a) **Projecting Service Expenditures.** Each yearly estimate of Medicaid Reform service expenditures will be the cost projections for the SSI and TANF MEGs defined below. The annual budget estimate for each MEG will be the product of the projected per capita cost per month (PCCM) cost for the MEG, times the actual number of eligible member months as reported to CMS by the State under the guidelines set forth in section X.

b) **Projected PCCM Cost.** Projected PCCM for each MEG has been calculated by using a pre-determined trend rates to convert the base year per capita costs into annual projected per capita costs for each year of the demonstration. Rates of 8 and 8 percent apply to the SSI and TANF MEGs respectively. The monthly equivalent growth rates are: .643403 and .643403 percent for each MEG and have been used to convert Base Year/State fiscal year (FFY) PCCM cost estimates to Demonstration Year (DY) estimates. The agreement to use these trend rates is based on analysis of State and National data.

The base year and projected DY PCCM amounts are the following (using July 1, 2006 as start date for the demonstration):

Time Period	SSI MEG	TANF MEG
Base Year	$753.18	$158.35
DY 01 (SFY 2006-2007)	$948.79	$199.48
DY 02 (SFY 2007-2008)	$ 1,024.69	$215.44
DY 03 (SFY 2008-2009)	$ 1,106.67	$232.68
DY 04 (SFY 2009-2010)	$ 1,195.20	$251.29
DY 05 (SFY 2010-2011)	$ 1,290.82	$271.39

c) Converting PCCM to an Alternative Start Date. Because the beginning demonstration may deviate from the expected start date, the following

methodology may be used to produce revised DY estimates of PCCM amounts. Using the monthly equivalent growth rate, the appropriate number of monthly trend rates would be used to convert base year PCCM costs to PCCM costs for the first DY. After the first DY, the annual trend factor will be used to trend forward from one year to the next. (This procedure is described more fully in the sample calculations presented below.)

Sample Calculations

First Demonstration Year:
As an example, assume that a base year (SFY 2000) per capita cost for the enrolled population is $1,000, and the first year of the demonstration (DY 2001) is January 1, 2001, and ends December 31, 2001. DY 2001 is 18 months in time beyond SFY 2000; therefore, the monthly trend factor must be applied to trend SFY 2000 cost forward DY to 2001. Assume a trend rate of 5.2% and the associated monthly trend of .42336%. Applying the monthly trend factor to bring the base year estimate forward to DY 2001 results in PCCM cost of $1079. ($1079 = $1000 x 1.00423336^{18})

Second and Subsequent Demonstration Years:
Since DY 2002 is 12 months beyond DY 2001, 12 months of growth factor are needed. Applying the 5.2 percent growth factor to the estimated DY 2001 PCCM cost of $1079 gives a DY 2002 PCCM cost of $1135.

117. **How the Limit will be Applied**. The limits as defined in paragraphs 93 and 94 will apply to actual expenditures for demonstration, as reported by the State under Section XVIII. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

118. **Impermissible DSH, Taxes or Donations**. The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through SMD letters, other memoranda on or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

119. **Expenditure Review** CMS shall enforce budget neutrality over the life of the

demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, the State will calculate an annual expenditure target for the completed year and report it to CMS as part of the reporting guidelines in term and condition #22. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide for the PCCM budget limit, if the State exceeds the cumulative target, they shall submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

120. **Expenditure Review.** Expenditure through the low-income pool may not exceed the amounts determined by term and condition #93 – the annual contingent amount of $300 million must not be exceeded during applicable demonstration years of 02-05. The non-contingent amount during demonstration years 02-05 may not exceed $700 million, except as permitted by rollover amounts as guided by the following:

Year	Non-Contingent Low Income Pool Expenditures	Cumulative Amount
Year 1	$1 billion, providing implementation requirements are met	$1 billion
Year 2	$700 million	$1.7 billion
Year 3	$700 million	$2.4 billion
Year 4	$700 million	$3.1 billion
Year 5	$700 million	$3.8 billion